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Office of the Inspector General

California Medical Facility
Medical Inspection Results
Cycle 5

July 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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CALIFORNIA MEDICAL FACILITY
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EXECUTIVE SUMMARY

Pursuant to California Penal Code Section 6126 et seq., which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG conducts a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG **explicitly** makes no determination regarding the constitutionality of care in the prison setting. That determination is left to the Receiver and the federal court. The assessment of care by the OIG is just one factor in the court's determination whether care in the prisons meets constitutional standards. In Cycle 5, for the first time, the OIG will be inspecting institutions that have been delegated back to CDCR from the Receivership. There will be no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated.

The OIG's inspections are mandated by the Penal Code and not aimed at specifically resolving the court's questions on constitutional care. To the degree that they provide another factor for the court to consider, the OIG is pleased to provide added value to the taxpayers of California.

This fifth cycle of inspections will continue evaluating the areas addressed in Cycle 4, which included clinical case review, compliance testing, and a population-based metric comparison of selected Healthcare Effectiveness Data Information Set (HEDIS) measures. In agreement with stakeholders, the OIG made changes to both the case review and compliance components. The OIG found that in every inspection in Cycle 4, larger samples were taken than were needed to assess the adequacy of medical care provided. As a result, the OIG reduced the number of case reviews and sample sizes for compliance testing. Also, in Cycle 4, compliance testing included two secondary (administrative) indicators (*Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*). For Cycle 5, these have been combined into one secondary indicator, *Administrative Operations*.

Overall Assessment: Inadequate

The OIG performed its Cycle 5 medical inspection at the California Medical Facility (CMF) from January to March 2017. The inspection included in-depth reviews of 58 patient files conducted by clinicians, as well as reviews of documents from 388 patient files, covering 89 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at CMF using 13 health care quality indicators applicable to the institution. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of registered nurses trained in monitoring medical policy compliance. Of the indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and three were rated by compliance inspectors only. The *CMF Executive Summary Table* on the following page identifies the applicable individual indicators and scores for this institution.

CMF Executive Summary Table

Inspection Indicators	Case Review Rating	Compliance Rating	Cycle 5 Overall Rating	Cycle 4 Overall Rating
1—Access to Care	*Adequate*	*Adequate*	***Adequate***	*Adequate*
2—Diagnostic Services	*Adequate*	*Inadequate*	***Adequate***	*Adequate*
3—Emergency Services	*Adequate*	Not Applicable	***Adequate***	*Inadequate*
4—Health Information Management	*Inadequate*	*Inadequate*	***Inadequate***	*Adequate*
5—Health Care Environment	Not Applicable	*Adequate*	***Adequate***	*Inadequate*
6—Inter- and Intra-System Transfers	*Inadequate*	*Inadequate*	***Inadequate***	*Adequate*
7—Pharmacy and Medication Management	*Adequate*	*Adequate*	***Adequate***	*Inadequate*
8—Prenatal and Post-Delivery Services	Not Applicable	Not Applicable	Not Applicable	Not Applicable
9—Preventive Services	Not Applicable	*Inadequate*	***Inadequate***	*Inadequate*
10—Quality of Nursing Performance	*Inadequate*	Not Applicable	***Inadequate***	*Inadequate*
11—Quality of Provider Performance	*Inadequate*	Not Applicable	***Inadequate***	*Adequate*
12—Reception Center Arrivals	Not Applicable	Not Applicable	Not Applicable	Not Applicable
13—Specialized Medical Housing	*Inadequate*	*Proficient*	***Inadequate***	*Adequate*
14—Specialty Services	*Adequate*	*Inadequate*	***Inadequate***	*Adequate*
15—Administrative Operations (Secondary)	Not Applicable	*Adequate*	***Adequate***	*Inadequate**

*In Cycle 4, there were two secondary (administrative) indicators. This score reflects the average of those two scores.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,589 patient care events.[1] Of the 13 indicators applicable to CMF, 10 were evaluated by clinician case review; 5 were *adequate*, and 5 were *inadequate.* When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- During this period of review, CMF provided good access to primary care services.
- CMF provided good diagnostic services, with diagnostic services being performed in a timely manner.
- CTC and OHU providers performed at high levels. Providers documented comprehensive history and physical exams as well as detailed discharge summaries that showed a thorough review of medical records. Providers also demonstrated excellent assessment and decision-making during patient care.
- Physicians and pharmacists performed well with anticoagulation services.
- CMF had recently hired a new chief nurse executive (CNE), who had initiated new activities, such as "Town Hall meetings," and included staff nurses on some committees. The CNE communicated well with staff, and nurses were optimistic that morale was improving.
- CMF was fortunate to employ RNs certified in advanced cardiac life support (ACLS) who are permanently posted in the triage and treatment area (TTA).

Program Weaknesses — Clinical

- CMF had significant problems with transmission of information from specialists to providers. CMF gave higher priority to scanning specialty reports directly into the electronic medical record than to ensuring providers' knowledge of them. Due to this process, specialty reports were often not made available to providers to review within three business days per California Correctional Health Care Services (CCHCS) policy, ultimately delaying medical care.

[1] Each OIG clinician team includes a board-certified physician and registered nurse consultant with experience in correctional and community medical settings.

- While the new CNE at CMF was actively implementing important quality improvements, this position had only recently been filled. CMF previously lacked stability in this important nursing position. This absence of a permanent CNE may have contributed to the poor nursing care observed at CMF.

- CMF had been unable to hire and retain qualified physicians in recent years, resulting in a shortage of physicians. At the time of the onsite inspection, CMF had four vacant provider positions.

- The institution's leadership failed to address serious provider performance deficiencies found in the OIG's Cycle 4 inspection. The OIG found these same types of deficiencies in Cycle 5, which strongly influenced the *inadequate* rating of the *Quality of Provider Performance* indicator. The institution's internal process of provider evaluation was flawed because patients with simple medical issues were selected to determine provider performance. This review process did not accurately reflect the patient population at CMF, the majority of whom had complex medical issues. Substandard provider care cannot be readily identified by the use of such a selective and limited low-risk patient pool.

- Provider documentation was sometime scant. Certain providers failed to document their thought process and reasoning in progress notes, resulting in inadequate care management. Provider progress notes were also handwritten and illegible.

- CMF nurses did not consistently provide an acceptable quality of care. Sick call nurses often did not perform face-to-face assessments.

- CTC and OHU nurses did not provide adequate care for patients who were at risk of a fall or who had fallen. When a patient fell, an RN did not always assess the patient for injuries and did not reassess the patient's fall risk. Nurses did not always notify the provider or initiate nursing interventions to reduce the risk of future falls.

- CMF's primary care team's process was inadequate for reporting important issues such as patient non-compliance with warfarin (blood thinner), and dangerously elevated blood glucose levels. In addition, the medication nurses failed to notify the clinical pharmacist whenever a patient refused his warfarin.

Compliance Testing Results

Of the 13 health care indicators applicable to CMF, 10 were evaluated by compliance inspectors.[2] One was *proficient*, four were *adequate*, and five were *inadequate.* There were 89 individual compliance questions within those 10 indicators, generating 1,122 data points that tested CMF's

[2] The OIG's compliance inspectors are trained registered nurses with expertise in CDCR policies regarding medical staff and processes.

compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 89 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

The following are some of CMF's strengths based on its compliance scores on individual questions in all the health care indicators:

- Registered nurses at CMF reviewed patients' requests for medical care on the same day they were received, and patients received sick call follow-up appointments with a provider within required time frames.
- Providers at CMF timely reviewed laboratory studies and reported the results to their patients.
- Clinics at CMF were appropriately disinfected, cleaned, and sanitary; and reusable invasive and non-invasive equipment was properly sanitized. In addition, health care staff at clinic locations followed proper protocols to mitigate exposure to blood borne pathogens and contaminated waste, and clinic common areas had environments conducive to providing medical services.
- Nursing staff practiced appropriate hand hygiene at medication line locations, and employed appropriate administrative controls and protocols during medication preparation.
- The institution offered influenza vaccinations and colorectal cancer screenings within required time frames.
- CMF promptly processed medical appeals in the last 12 months, and the institution addressed second-level appeals within required time frames.

Program Weaknesses — Compliance

The following are some of the weaknesses identified by CMF's compliance scores on individual questions in all the health care indicators:

- Providers did not timely review their patients' radiology and pathology study results.
- Providers did not review patient hospital discharge summaries timely.
- Nursing staff did not properly complete the initial health screening assessment for patients transferred from another institution; specifically, nursing staff did not answer all of the required questions.

[3] The OIG used its own clinicians to provide clinical expert guidance for testing compliance in certain areas where CCHCS policies and procedures did not specifically address an issue.

- Patients receiving medications for chronic care conditions did not always receive their medications as ordered, and patients returning from a community hospital also did not receive their medication within required time frames.

- Nursing staff did not always maintain adequate security controls over narcotic medications, as inspectors found several narcotic inventory counts that were not completed by two licensed nursing staff.

- CMF did not always monitor its patients receiving tuberculosis (TB) medications, or provide annual TB screening as required by CCHCS policy.

- Clinicians at CMF did not evidence timely review of high-priority and routine specialty service consultant reports.

- Patients who transferred to CMF from other CDCR facilities with approved specialty service appointments did not always timely receive those appointments.

Population-Based Metrics

In general, CMF performed well as measured by population-based metrics. In comprehensive diabetes care, CMF performed better than or comparably to other state and national organizations in most measures. With regard to immunization measures, CMF's rates were very high. The institution's score for colorectal cancer screening, however, was very low, but it was negatively affected by a significant patient refusal rate. Overall, CMF's performance demonstrated by the population-based metrics indicated that the chronic care program was operating well, and the institution had an opportunity to improve by providing patient education about the benefits of colorectal cancer screenings.

INTRODUCTION

Pursuant to California Penal Code Section 6126 et seq., which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), and at the request of the federal Receiver, the OIG developed a comprehensive medical inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG conducts a clinical case review and a compliance inspection, ensuring a thorough, end-to-end assessment of medical care within CDCR.

California Medical Facility (CMF) was the second medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The Administrative Operations indicator is purely administrative and is not reflective of the actual clinical care provided, and it does not factor in the overall rating for the institution.

ABOUT THE INSTITUTION

Located in Vacaville, California Medical Facility (CMF) was established in 1955 by the Legislature to provide a centrally located facility to meet the medical and psychiatric health care needs of male patients incarcerated within CDCR. CMF provides health care to patients who reside in a number of settings, including general population, outpatient housing units (OHUs), a licensed correctional treatment center (CTC), a licensed mental health crisis bed CTC, outpatient psychiatric facilities, and the first licensed prison hospice in the United States. CMF is designated an "intermediate care" facility; these institutions are located in predominantly urban areas close to tertiary care centers and specialty care providers for the most cost-effective care. CMF serves as a resource to the rest of CDCR and contracts with community consultants and hospital facilities to meet the complex needs of its patient population.

On August 16, 2015, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data the OIG obtained from the institution, CMF's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 11 percent in January 2017. The highest vacancy percentage was among management with a vacancy rate of 60 percent, which equated to three of five authorized positions. Among primary care providers, the vacancy rate was 25 percent.

CMF Health Care Staffing Resources as of January, 2017

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	2%	17	6%	24.2	9%	221.2	83%	267.4	100%
Filled Positions	2	40%	12.8	75%	20	83%	203	92%	237.8	89%
Vacancies	3	60%	4.2	25%	4.2	17%	18.2	8%	29.6	11%
Recent Hires (within 12 months)	0	0%	2	16%	6	30%	25	12%	33	14%
Staff Utilized from Registry	0	0%	1	8%	0	0%	17	8%	18	8%
Redirected Staff (to Non-Patient Care Areas)	1	50%	0	0%	0	0%	1	0%	2	1%
Staff on Long-term Medical Leave	0	0%	0	0%	1	5%	17	8%	18	8%

Note: CMF Health Care Staffing Resources data was not validated by the OIG.

As of January 16, 2017, the Master Registry for CMF showed that the institution had a total population of 2,501. Within that total population, 20.4 percent were designated as high medical risk, Priority 1 (High 1), and 29.3 percent were designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory tests and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

CMF Master Registry Data as of January 16, 2017

Medical Risk Level	Number of Patients	Percentage
High 1	511	20.4%
High 2	732	29.3%
Medium	970	38.8%
Low	288	11.5%
Total	**2,501**	**100.0%**

OBJECTIVES, SCOPE, AND METHODOLOGY

In designing the medical inspection program, the OIG reviewed CCHCS policies and procedures, relevant court orders, and guidance developed by the American Correctional Association. The OIG also reviewed professional literature on correctional medical care; reviewed standardized performance measures used by the health care industry; consulted with clinical experts; and met with stakeholders from the court, the Receiver's office, CDCR, the Office of the Attorney General, and the Prison Law Office to discuss the nature and scope of the OIG's inspection program. With input from these stakeholders, the OIG developed a medical inspection program that evaluates medical care delivery by combining clinical case reviews of patient files, objective tests of compliance with policies and procedures, and an analysis of outcomes for certain population-based metrics.

To maintain a metric-oriented inspection program that evaluates medical care delivery consistently at each state prison, the OIG identified 15 indicators (14 primary (clinical) indicators and one secondary (administrative) indicator) of health care to measure. The primary quality indicators cover clinical categories directly relating to the health care provided to patients, whereas the secondary quality indicator addresses the administrative functions that support a health care delivery system. These 15 indicators are identified in the *CMF Executive Summary Table* on page *ii* in the *Executive Summary* of this report.

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG registered nurses. The ratings may be derived from the case review results alone, the compliance test results alone, or a combination of both these information sources. For example, the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* are derived entirely from the case review done by clinicians, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance testing done by registered nurse inspectors. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources.

Consistent with the OIG's agreement with the Receiver, this report only addresses the conditions found related to medical care criteria. The OIG does not review for efficiency and economy of operations. Moreover, if the OIG learns of a patient needing immediate care, the OIG notifies the chief executive officer of health care services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report such departures to the institution's chief executive officer or to CCHCS. Because these matters involve confidential medical information protected by state and federal privacy laws, specific identifying details related to any such cases are not included in the OIG's public report.

In all areas, the OIG is alert for opportunities to make appropriate recommendations for improvement. Such opportunities may be present regardless of the score awarded to any particular

quality indicator; therefore, recommendations for improvement should not necessarily be interpreted as indicative of deficient medical care delivery.

CASE REVIEWS

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in Cycle 5 medical inspections. The OIG's clinicians perform a retrospective chart review of selected patient files to evaluate the care given by an institution's primary care providers and nurses. Retrospective chart review is a well-established review process used by health care organizations that perform peer reviews and patient death reviews. Currently, CCHCS uses retrospective chart review as part of its death review process and in its pattern-of-practice reviews. CCHCS also uses a more limited form of retrospective chart review when performing appraisals of individual primary care providers.

Patient Selection for Retrospective Case Reviews

Because retrospective chart review is time consuming and requires qualified health care professionals to perform it, OIG clinicians must carefully sample patient records. Accordingly, the group of patients the OIG targeted for chart review carried the highest clinical risk and utilized the majority of medical services. A majority of the patients selected for retrospective chart review were classified by CCHCS as high-risk patients. The reason the OIG targeted these patients for review is twofold:

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a disproportionate rate; 11 percent of the total patient population are considered high-risk and account for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.

2. Selecting this target group for chart review provides a significantly greater opportunity to evaluate all the various aspects of the health care delivery system at an institution.

Underlying the choice of high-risk patients for detailed case review, the OIG clinical experts made the following three assumptions:

1. If the institution is able to provide adequate clinical care to the most challenging patients with multiple complex and interdependent medical problems, it will be providing adequate care to patients with less complicated health care issues. Because clinical expertise is required to determine whether the institution has provided adequate clinical care, the OIG utilizes experienced correctional physicians and registered nurses to perform this analysis.

2. The health of less complex patients is more likely to be affected by processes such as timely appointment scheduling, medication management, routine health screening, and

immunizations. To review these processes, the OIG simultaneously performs a broad compliance review.

3. Patient charts generated during death reviews, sentinel events (unexpected occurrences involving death or serious injury, or risk thereof), and hospitalizations are mostly of high-risk patients.

Benefits and Limitations of Targeted Subpopulation Review

Because the selected patients utilize the broadest range of services offered by the health care system, the OIG's retrospective chart review provides adequate data for a qualitative assessment of the most vital system processes (referred to as "primary quality indicators"). Retrospective chart review provides an accurate qualitative assessment of the relevant primary quality indicators as applied to the targeted subpopulation of high-risk and high-utilization patients. While this targeted subpopulation does not represent the prison population as a whole, the ability of the institution to provide adequate care to this subpopulation is a crucial and vital indicator of how the institution provides health care to its whole patient population. Simply put, if the institution's medical system does not adequately care for those patients needing the most care, then it is not fulfilling its obligations, even if it takes good care of patients with less complex medical needs.

Since the targeted subpopulation does not represent the institution's general prison population, the OIG cautions against inappropriate extrapolation of conclusions from the retrospective chart reviews to the general population. For example, if the high-risk diabetic patients reviewed have poorly-controlled diabetes, one cannot conclude that the entire diabetic population is inadequately controlled. Similarly, if the high-risk diabetic patients under review have poor outcomes and require significant specialty interventions, one cannot conclude that the entire diabetic population is having similarly poor outcomes.

Nonetheless, the health care system's response to this subpopulation can be accurately evaluated and yields valuable systems information. In the above example, if the health care system is providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it can be reasonably inferred that the health care system is also providing appropriate diabetic services to the entire diabetic subpopulation. However, if these same high-risk patients needing monitoring, medications, and referrals are generally not getting those services, it is likely that the health care system is not providing appropriate diabetic services to the greater diabetic subpopulation.

Case Reviews Sampled

As indicated in *Appendix B, Table B–1: CMF Sample Sets*, the OIG clinicians evaluated medical charts for 58 unique patients. *Appendix B, Table B–4: CMF Case Review Sample Summary* clarifies that both nurses and physicians reviewed charts for 14 of those patients, for 72 reviews in total. Physicians performed detailed reviews of 25 charts, and nurses performed detailed reviews of 15

charts, totaling 40 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 32 patients. These generated 1,589 clinical events for review (*Appendix B, Table B–3: CMF Event-Program*). The inspection tool provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only 6 chronic care patient records, i.e., 3 diabetes patients and 3 anticoagulation patients (*Appendix B, Table B–1: CMF Sample Sets*), the 58 unique patients sampled included patients with 275 chronic care diagnoses, including 26 additional patients with diabetes (for a total of 29) and one additional anticoagulation patient (for a total of 4) (*Appendix B, Table B–2: CMF Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy.

The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG found the Cycle 4 medical inspection physician sample size of 30 detailed reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the case review results were analyzed using 50 percent of the cases, finding no significant differences in the ratings. To improve inspection efficiency, while preserving the quality of the inspection, the samples for Cycle 5 medical inspections were reduced in number of cases. For Cycle 5 inspections of basic institutions with few high-risk patients, case review will use 67 percent of the case review samples used in Cycle 4 inspections (20 detailed physician-reviewed cases). For intermediate institutions or basic institutions housing many high-risk patients, the case review samples will use 83 percent (25 detailed physician-reviewed cases). For CMF, the OIG used an 83 percent case review sample size compared to Cycle 4 because CMF had many high-risk patients. Finally, the most medically complex institution, CHCF, has retained the full 100 percent sample sizes used in Cycle 4 inspections.

With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by each provider at the institution, the OIG inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing providers care for the less complicated, low-utilizing, and lower-risk patients. The OIG's clinicians concluded that the case review sample size was more than adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *CMF Supplemental Medical Inspection Results: Individual Case Review Summaries* report details the case reviews OIG clinicians conducted and is available to specific stakeholders. For further details regarding the sampling methodologies and counts, see *Appendix B — Clinical Data, Table B–1; Table B–2; Table B–3;* and *Table B–4*.

COMPLIANCE TESTING

Sampling Methods for Conducting Compliance Testing

From January to March 2017, registered nurse inspectors attained answers to 89 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 388 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of January 30, 2017, field registered nurse inspectors conducted a detailed onsite inspection of CMF's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,122 scored data points to assess care.

In addition to the scored questions, the OIG obtained information from the institution that it did not score. This included, for example, information about CMF's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

For Cycle 5 medical inspection testing, the OIG reduced the number of compliance samples tested for 18 indicator tests from a sample of 30 patients to a sample of 25 patients. The OIG also removed some inspection tests upon stakeholder agreement that either were duplicated in the case reviews or had limited value. Lastly, for Cycle 4 medical inspections, the OIG tested two secondary (administrative) indicators; *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications,* and have combined these tests into one *Administrative Operations* indicator for Cycle 5 inspections.

For details of the compliance results, see *Appendix A — Compliance Test Results*. For details of the OIG's compliance sampling methodology, see *Appendix C — Compliance Sampling Methodology*.

Scoring of Compliance Testing Results

After compiling the answers to the 89 questions for the 10 applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

The OIG derived the final rating for each quality indicator by combining the ratings from the case reviews and from the compliance testing, as applicable. When combining these ratings, the case review evaluations and the compliance testing results usually agreed, but there were instances when the rating differed for a particular quality indicator. In those instances, the inspection team assessed the quality indicator based on the collective ratings from both components. Specifically, the OIG clinicians and registered nurse inspectors discussed the nature of individual exceptions found within that indicator category and considered the overall effect on the ability of patients to receive adequate medical care.

To derive an overall assessment rating of the institution's medical inspection, the OIG evaluated the various rating categories assigned to each of the quality indicators applicable to the institution, giving more weight to the rating results of the primary quality indicators, which directly relate to the health care provided to patients. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed.

POPULATION-BASED METRICS

The OIG identified a subset of Healthcare Effectiveness Data Information Set (HEDIS) measures applicable to the CDCR patient population. To identify outcomes for CMF, the OIG reviewed some of the compliance testing results, randomly sampled additional patients' records, and obtained CMF's data from the CCHCS Master Registry. The OIG compared those results to HEDIS metrics reported by other statewide and national health care organizations.

MEDICAL INSPECTION RESULTS

The quality indicators assess the clinical aspects of health care. As shown on the *CMF Executive Summary Table* on page *ii* of this report, 13 of the OIG's indicators were applicable to CMF. Of those 13 indicators, 7 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 3 were rated by the compliance component alone. The *Administrative Operations* indicator is a secondary indicator, and, therefore, did not affect the overall score for the institution. Based on the analysis and results in all the primary indicators, the OIG experts made a considered and measured opinion that the quality of health care at CMF was ***inadequate***.

Summary of Case Review Results: The clinical case review component assessed 10 of the 13 indicators applicable to CMF. Of these ten indicators, OIG clinicians rated zero *proficient,* five *adequate,* and five *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 18 were *adequate,* one was *proficient,* and 6 were *inadequate*. In the 1,589 events reviewed, there were 553 deficiencies, of which 143 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Events Identified During Case Review: Adverse events are medical errors that are more likely than not to cause serious patient harm. Medical care is a complex dynamic process with many moving parts, subject to human error even within the best health care organizations. Adverse events are typically identified and tracked by all major health care organizations for the purpose of quality improvement. They are not generally representative of medical care delivered by the organization. The OIG identified adverse events for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal description of these events, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse events. There were four adverse events identified in the case reviews at CMF, including one potentially preventable death.

Potentially Preventable Death

- In case 4, the patient had a critically elevated blood pressure. The provider failed to transfer the patient to the TTA for further monitoring and treatment. The provider discharged the patient without treating his elevated blood pressure. The patient was found unresponsive 11 days later. He was pronounced dead in the TTA. This death may have been prevented if providers had appropriately addressed and treated the patient's uncontrolled blood pressure.

Other Adverse Events

- Also in case 4, on an earlier date, the patient had an elevated blood pressure. The provider did not recheck the patient's blood pressure and sent him back to his housing unit without

treating his elevated blood pressure. The provider failed to transfer the patient to a higher level of care, such as the TTA, for closer monitoring. The provider failed to order a timely nurse follow-up to monitor the patient's blood pressure. Although the provider documented that the patient was on a blood pressure medication that needed to be adjusted for his kidney failure, the provider failed to order another class of blood pressure medication that was not affected by kidney function.

- In case 10, the patient was already on a very high dose of morphine when the provider increased the patient's total morphine dose even higher to an unsafe dose. The provider failed to document any reason this level of morphine was needed. The patient was hospitalized for an overdose of morphine the following month.

- In case 23, the provider ordered an antibiotic for a patient returning from the hospital for sepsis, a life-threatening infection. However, the pharmacy failed to process the order, so the patient never received the medication. This was a significant lapse in medical care. Subsequently, the patient developed a recurrent infection that required a repeat hospitalization. This second hospitalization may have been prevented if the patient had initially received the antibiotic treatment.

Summary of Compliance Results: The compliance component assessed 10 of the 13 indicators applicable to CMF. Of these ten indicators, OIG inspectors rated one *proficient*, four *adequate*, and five *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

1 — *ACCESS TO CARE*

This indicator evaluates the institution's ability to provide patients with timely clinical appointments. Areas specific to patients' access to care are reviewed, such as initial assessments of newly arriving patients, acute and chronic care follow-ups, face-to-face nurse appointments when an patient requests to be seen, provider referrals from nursing lines, and follow-ups after hospitalization or specialty care. Compliance testing for this indicator also evaluates whether patients have Health Care Services Request forms (CDCR Form 7362) available in their housing units.

Case Review Rating:
Adequate
Compliance Score:
Adequate
(80.6%)

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 583 provider, nursing, specialty, and outside hospital encounters; they identified 44 deficiencies relating to access to care, of which 14 were significant. The OIG clinicians rated the *Access to Care* indicator at CMF *adequate*.

Provider Follow-up Appointments

The institution performed well with provider-ordered follow-up appointments. These are among the most important aspects of the *Access to Care* indicator. Failure to accommodate provider-ordered appointments can often result in lapses in care or can even result in patients being lost to follow-up. The OIG clinicians reviewed 183 outpatient provider encounters and noted 7 significant deficiencies that resulted entirely from a scheduling oversight. Although infrequent, such errors placed patients at significant risk of harm. Appointments that were totally dropped were identified in cases 10, 13, 39, 42, and the following case:

- In case 4, the patient's urine culture confirmed he had a urinary tract infection. The provider ordered a short interval follow-up of three to five days, which did not occur.

Failure to accommodate provider-ordered appointments within the specified time frame can often result in delays or even lapses in medical care. Therefore, this deficiency is also considered an access to care issue. CMF performed adequately in this area. Delays in appointments were found in cases 4, 9, 13, 14, 22, 24, 26, 27, 42, and 60.

RN Sick Call Process

The OIG clinicians identified significant deficiencies in nursing performance. As was also found in the Cycle 4 inspection, nurses often failed to see patients face to face for nursing assessments in response to patients' sick call requests. These deficiencies are addressed, and more heavily weighted in the *Quality of Nursing Performance* indicator. However, CMF provided timely nursing appointments when patients were referred to a nurse related to sick call requests.

Nurse-to-Provider Referrals

Nurses performing sick call assessments are required to refer patients to a provider if situations require higher levels of care. One type of deficiency, also found by the OIG in Cycle 4 and further discussed in the *Quality of Nursing Performance* indicator, was the nurses' practice of deferring sick call issues to the next scheduled provider appointment, which either did not occur as scheduled or exceeded the 14-day time frame for routine referrals.

Provider-to-Nurse Referrals

The OIG clinicians identified two significant deficiencies in nurse appointments generated by a provider.

- In case 12, the patient injured his knee after a fall. The provider ordered a seven-day nurse follow-up, but it did not occur.

- In case 13, the provider ordered a nurse follow-up for the patient's abscesses, but the follow-up did not occur.

TTA-to-Nurse Referrals

- In case 13, a TTA order for a nurse follow-up was delayed three days. This was for a patient who had been placed in isolation with an infectious condition.

Provider Follow-up After Specialty Service

The institution consistently provided patients with provider follow-ups after specialty services. The OIG clinicians reviewed 185 diagnostic and consultative specialty services and found only one instance in which a provider follow-up had been delayed.

Intra-System Transfers

Nurses assessed newly transferred patients and always referred them to a provider. The OIG clinicians reviewed nine patients transferring into CMF and found no deficiencies with access to care in this area.

Follow-up After Hospitalization

The institution had no difficulty ensuring that providers saw their patients after the patients returned from an outside hospital or an emergency department. CMF had 23 hospitalization and outside emergency events. There was one significant deficiency with access to care in this area.

Urgent/Emergent Care

CMF generally ensured that the providers or the clinic nurses evaluated patients in the TTA. The OIG clinicians reviewed 33 urgent or emergent encounters, of which 15 required a provider or a nurse follow-up. The OIG clinicians found provider follow-up was delayed only in case 10.

Specialized Medical Housing

CMF performed adequately with provider access during and after admission to the OHU and CTC. A provider usually visited the OHU and CTC patients at appropriate time intervals. The OIG clinicians reviewed 10 OHU and CTC admissions with 136 provider encounters. There were three instances in which a provider failed to follow up with CTC patients according to policy. The three deficiencies were in cases 8, 10, and 28.

RN Case Management

The primary care team RN fulfilled the role of RN case manager. This responsibility is discussed in the *Quality of Nursing Performance* indicator.

Specialty Access

Access to specialty services is discussed in the *Specialty Services* indicator.

Clinician Onsite Inspection

The potential future problem at CMF was provider vacancies. At the time of the onsite inspection, CMF had four vacant provider positions. While there were 11 functional provider positions, two of the providers were currently on maternity leave. CMF was using one telemedicine physician to temporarily help increase the availability of providers. Each provider saw an average of 14 to 15 patients per day with no patient backlog in the ambulatory care clinics. This lack of a backlog was due, in part, to the highly seasoned and experienced physicians at CMF. Furthermore, some of these physicians had practiced at CMF for over ten years. This consistency provided patients continuity of care and allowed them to benefit from having providers who understood the patient population and were highly experienced in managing these complex patients.

Clinician Summary

CMF demonstrated adequate ability to provide patients with access to care despite having vacant provider positions. The OIG clinicians found adequate performance in almost all areas, but there were delays in scheduled provider follow-up appointments. CMF had also improved in provider follow-up appointments after TTA visits since the OIG's Cycle 4 medical inspections. Therefore, the OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution scored an *adequate* 80.6 percent in the *Access to Care* indicator, with three tests scoring in the *proficient* range, as follows:

- Patients had access to Health Care Services Request forms (CDCR Form 7362) at all six housing units the OIG inspected (MIT 1.101).

- Inspectors sampled 30 request forms submitted by patients across all facility clinics. Nursing staff reviewed all services request forms on the same day they were received (MIT 1.003).

- Of the 11 sampled patients who were referred to and seen by a provider and for whom the provider subsequently ordered a follow up appointment, 10 (90 percent) received their follow-up appointments timely. One patient was seen three days late (MIT 1.006).

Three tests earned *adequate* scores:

- Among 25 sampled patients discharged from a community hospital, 21 (84 percent) received a timely provider follow-up appointment upon their return to CMF. Three patients received their follow-up appointments from two to nine days late, while one patient did not receive a follow-up at all (MIT 1.007).

- For 25 of the 30 patients sampled who submitted health care services request forms (83 percent), nursing staff completed a face-to-face encounter within one business day of reviewing the form. For the remaining five patients, the nurse did not conduct a face-to-face visit (MIT 1.004).

- When the OIG reviewed recent appointments for 25 sampled patients with chronic care conditions, 20 patients (80 percent) received timely provider follow-up appointments. Three patients received chronic care appointments from 4 to 16 days late, and two other patients received chronic care appointments 45 and 48 days late (MIT 1.001).

The institution showed room for improvement in the following three areas:

- Inspectors tested 25 patients discharged from a community hospital to determine if they received a provider follow-up appointment at CMF within five calendar days of returning to the institution, or earlier if a TTA provider ordered the appointment to occur sooner. Only 13 of the patients (52 percent) received a timely provider follow up appointment. Six patients received their appointments from one to five days late; two patients received their appointments eight and nine days late. Two other patients received their appointments 28 and 48 days late. Lastly, two patients never received a follow-up appointment at all (MIT 1.008).

- Among 25 patients sampled who transferred into CMF from other institutions and were referred to a provider based on nursing staff's initial health care screening, only 16

(64 percent) were seen timely. Nine patients received their provider appointment from one to seven days late (MIT 1.002).

- Among 14 health care services request forms sampled on which nursing staff referred the patient for a provider appointment, only ten patients (71 percent) received a timely appointment. Two patients received their appointments one and three days late. Two patients received their appointments 35 and 40 days late (MIT 1.005).

Recommendations

No specific recommendations.

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(64.9%)

Overall Rating:
Adequate

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to patients, whether the primary care provider timely reviewed the results, and whether the results were communicated to the patient within the required time frames. In addition, for pathology services, the OIG determines whether the institution received a final pathology report and whether the provider timely reviewed and communicated the pathology results to the patient. The case reviews also factor in the appropriateness, accuracy, and quality of the diagnostic test(s) ordered and the clinical response to the results.

For this indicator, the OIG's case review and compliance testing processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in an *inadequate* score. Compliance review identified several diagnostic errors related to health information management, while case review identified only infrequent instances of diagnostic tests not being timely completed. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate*.

Case Review Results

The OIG clinicians reviewed 305 diagnostic events at CMF and found 62 deficiencies, of which 31 were significant; 22 of these significant deficiencies regarded health information management.

- Laboratory and diagnostic reports were not retrieved and scanned into the electronic medical record in cases 4, 9, 11, 22, 26, and 28. This type of failure increases the risk of patient harm or lapse in care as the ordering provider or subsequent providers may not be aware of this pertinent information being available to them. The specific cases are discussed in the *Health Information Management* indicator of this report.

Test reports that were never retrieved or reviewed were considered just as severe a problem as tests that were not completed as ordered. The institution performed the majority of diagnostic services in a timely manner. However, not conducting diagnostic tests as ordered is a serious deficiency that can potentially lead to significant delays or even lapses in medical care. Errors such as these at CMF were uncommon, but did occur more frequently when tests were ordered with longer processing time frames. Laboratory tests that were ordered by the provider but never processed by the laboratory were found in cases 17, 25, and the following cases.

- In case 9, the clinical pharmacist requested the patient have an INR test (laboratory test to monitor blood thinning), but it was never scheduled. As a result, this information was not available to the clinical pharmacist in follow-up at the warfarin clinic, so the patient needed

an additional appointment. This failure not only delayed the patient's medical care, but also generated an unnecessary follow-up.

- In case 26, the laboratory failed to complete tests that were used to monitor the patient's transplanted kidney for an entire month. This was a significant lapse because the patient's kidney function had worsened, which could have indicated transplant rejection. Medical providers were unaware of the worsening condition until the following month when these tests were actually completed.

There were delays from a few days to two weeks in the collection of laboratory results were found in cases 4, 12, 13, 17, and 19.

Eight of the significant deficiencies occurred in appointments and scheduling (once each in cases 9, 11, 26, and 53, and twice each in cases 13 and 25).

Clinician Onsite Inspection

Although the occurrence was low, the OIG clinicians inquired about the laboratory tests that were not conducted as ordered at CMF. The laboratory supervisor explained that a few of these laboratory tests had not been completed because the laboratory had not received the orders, but there was no explanation for the other tests that were not conducted.

CMF demonstrated poor performance with the retrieval and scanning of radiology reports from the radiology information system (RIS) into the primary electronic medical record, which was also found in the Cycle 4 onsite inspection. The OIG clinicians continue to maintain that if providers are unaware of radiology reports, an increased risk of patient harm persists due to potential lapses in provider care. Furthermore, the absence of radiology reports from the electronic medical record continues to pose a tremendous barrier to maintaining continuity of care for patients because subsequent medical staff do not have knowledge of these critically important diagnostic reports.

Clinician Summary

While CMF occasionally had difficulty collecting and processing laboratory tests by the dates indicated by providers, this was not a common occurrence. The majority of diagnostic services were performed and completed in a timely manner. However, the failure by medical records staff to retrieve and scan diagnostic reports prevented CMF from attaining the highest rating in this category. This continued failure to retrieve radiology reports from RIS and scan them into the primary medical record presented an ongoing risk for lapses in patient care. CMF generally did well in most aspects of diagnostic services. Therefore, the OIG clinicians rated this indicator *adequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 64.9 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- Radiology services were timely performed for nine of ten patients sampled (90 percent); one patient received the service one day late (MIT 2.001). CMF providers did not timely review the corresponding diagnostic services reports for the ten sampled patients and thus received a score of zero (MIT 2.002). Providers timely communicated the test results to nine of the ten sampled patients (90 percent); one result was communicated to the patient five days late (MIT 2.003).

Laboratory Services

- Eight of ten sampled patients (80 percent) received their provider-ordered laboratory services timely, while two services were each one day late (MIT 2.004). The institution's providers also reviewed nine of the ten resulting laboratory reports within the required time frame (90 percent); one report was initialed but it did not contain a date of review (MIT 2.005). Finally, providers timely communicated laboratory results to all ten patients (MIT 2.006).

Pathology Services

- CMF received nine of the ten final pathology reports timely (90 percent). One report was not received (MIT 2.007). Providers did not evidence review of any of the nine applicable final pathology reports, for a score of zero (MIT 2.008). Further, providers timely communicated pathology results to only four of the nine applicable patients (44 percent). For two patients, the provider communicated the results 10 and 22 days late. For three additional patients, inspectors did not find evidence in the medical record that the provider communicated the test results at all (MIT 2.009).

Recommendation for CCHCS

The OIG continues to recommend that CCHCS revise its radiological report scanning policy and allow radiology reports to be scanned into the patient's electronic medical record.

Recommendation for CMF

The OIG recommends that CMF scan all future radiology reports into the electronic medical record.

3 — *EMERGENCY SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

An emergency medical response system is essential to providing effective and timely emergency medical response, assessment, treatment, and transportation 24 hours per day. Provision of urgent/emergent care is based on a patient's emergency situation, clinical condition, and need for a higher level of care. The OIG reviews emergency response services including first aid, basic life support (BLS), and advanced cardiac life support (ACLS) consistent with the American Heart Association guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiovascular care, and the provision of services by knowledgeable staff appropriate to each individual's training, certification, and authorized scope of practice.

The OIG evaluates this quality indicator entirely through clinicians' reviews of case files and conducts no separate compliance testing element.

Case Review Results

The OIG clinicians reviewed 49 urgent or emergent events and found 24 deficiencies with various aspects of emergency care. The OIG clinicians considered five of the 24 deficiencies to be significant, posing significant risk to the patient.

Provider Performance

Provider performance in emergency services was excellent, and is discussed in the *Quality of Provider Performance* indicator.

Nursing Performance

In general, nurses at CMF provided adequate care during emergency medical response incidents. Although the majority of the nursing deficiencies were not significant and did not affect the patient's outcome, several events demonstrated areas for improvement. One type of significant deficiency was delayed telephone contact with the on-call provider (also identified during the OIG Cycle 4 inspection). The following cases displayed this finding:

- In case 2, the TTA nurse did not contact the on-call provider for 30 minutes for an unresponsive patient with multiple head, neck, and arm stab wounds.

- In case 6, the TTA RN did not contact the on-call provider for 30 minutes for a patient with a history of significant cardiac disease with chest pain. The RN called 9-1-1 18 minutes after the provider ordered transfer to the outside emergency room. At the onsite inspection, the TTA nurse and the supervising registered nurse stated that the nurse delayed calling the provider because the patient was refusing treatment. The OIG clinicians, in contrast, contend

that the nurse should have notified the on-call provider as soon as possible of the patient's condition and his refusal of treatment.

A second type of deficiency consisted of failure to adequately assess and monitor the patient in the TTA:

- In case 4, nurses did not assess urinary output during the three and one-half hours the patient was in the TTA for renal failure.

- In case 22, the patient was vomiting. The TTA RN did not examine the patient's abdomen.

- In case 23, the TTA nurse did not reassess the patient for more than 40 minutes. The patient had a fever and low blood pressure.

Two other deficiencies were found:

- In case 3, the TTA nurse documented that the automatic external defibrillator (AED) indicated that the patient required two shocks during transport from the patient's housing unit to the TTA, but no one administered the shocks. At the onsite inspection, the TTA nursing supervisor stated this was an error in documentation and the nurse would make a late-entry progress note for correction. However, the late-entry documentation was not completed.

- In case 9, the onsite emergency responders, including an RN, performed CPR in the patient's housing unit. During an emergency medical response, when no provider is present, the RN is responsible for directing the care provided at the scene. The RN instructed the custody supervisor to call 9-1-1 and tell the responders to come directly to the housing unit. Instead, custody officers transported the patient to the TTA on the order of the custody supervisor. This action reduced the possibility of performing continuous, effective CPR during transport on a gurney. In the TTA, the nurse did not check the patient's blood glucose level or administer Narcan (narcotics overdose antidote) for suspected drug overdose.

Emergency Medical Response Review Committee

The Emergency Medical Response Committee (EMRRC) reviewed unscheduled medical transfers to community hospitals for higher levels of care, and generally reviewed cases and noted identified training needs appropriately.

Clinician Onsite Inspection

During the onsite visit, the OIG clinicians found the TTA patient care environment was neat and well organized but in a very tight space. Two of the four beds in the TTA were not equipped with cardiac monitors. These beds were used by the clinic LVNs for wound care, insulin administration, and other treatments, as well as for the provider procedure clinic. The TTA had two gurneys and

two emergency response bags for the two RNs always on duty. The RNs assigned to the TTA during the inspection were properly trained and ACLS certified.

Clinician Summary

The case reviews showed that, overall, patients requiring urgent and emergent services received adequate and timely care. The OIG rated the *Emergency Services* indicator at CMF *adequate*.

Recommendations

No specific recommendations.

4 — *HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(61.5%)

Overall Rating:
Inadequate

Health information management is a crucial link in the delivery of medical care. Medical personnel require accurate information in order to make sound judgments and decisions. This indicator examines whether the institution adequately manages its health care information. This includes determining whether the information is correctly labeled and organized and available in the electronic health record; whether the various medical records (internal and external, e.g., hospital and specialty reports and progress notes) are obtained and scanned timely into the patient's electronic health record; whether records routed to clinicians include legible signatures or stamps; and whether hospital discharge reports include key elements and are timely reviewed by providers.

During the OIG's testing period, CMF had not converted to the new Electronic Health Record System (EHRS); therefore, all testing occurred in the electronic Unit Health Record (eUHR) system.

Case Review Results

The OIG clinicians reviewed 1,583 events and found 146 deficiencies related to health information management. Of those 146 deficiencies, 28 were significant (once each in cases 9, 10, 14, 22, and 25; three times each in cases 11, 26, and 28; four times in case 4; and ten times in case 17).

Inter-Departmental Transmission

CMF demonstrated a severe pattern of missing documents across various areas of the institution. This pattern of missing documents became worse in this cycle compared to Cycle 4 since documents were also now missing in specialty and diagnostic services. Missing documents included clinic provider and nursing notes, diagnostic reports, medication administration records (MARs), specialty reports, and laboratory reports. Missing documents were identified in cases 4, 9, 10, 11, 14, 17, 22, 25, 26, and 28. The institution performed poorly with interdepartmental transmission of information, particularly with deficiencies related to the transmission of specialty reports:

- In case 10, a significant transmission error occurred when the nurses repeatedly failed to follow standing orders to notify the provider when the patient's finger stick blood glucose levels were extremely high.

- In case 14, the consulting telemedicine neurologist recommended a specific medication for the patient's headaches. However, the onsite telemedicine nurse failed to notify the provider about these recommendations. Because of this error, the patient's medication was not ordered until two weeks later.

Dictated Progress Notes

Occasionally notes were typed or transcribed, but most providers used handwritten progress notes. No transcription delays were identified.

Hospital Records

CMF did well with the retrieval of emergency department physician reports and hospital discharge summaries. The OIG clinicians reviewed three outside emergency department events and 20 other community hospital events. All emergency department reports and discharge summaries were retrieved and scanned timely. All hospital records were retrieved and scanned into the electronic medical record. CMF performed poorly with having the emergency department physician report or hospital discharge summaries reviewed and initialed by a provider. Initials were missing on the outside hospital and emergency department reports in almost all cases.

Specialty Services

CMF did poorly in health information management for specialty services. The OIG clinicians discovered significant problems in the review and scanning of the specialty reports. These findings are discussed in detail in the *Specialty Services* indicator.

Diagnostic Reports

The OIG clinicians found problems in the retrieval and scanning of diagnostic reports. There were 22 significant deficiencies for diagnostic reports. These findings are discussed in the *Diagnostic Services* indicator. Laboratory and diagnostic reports were not retrieved and scanned into the electronic medical record in cases 4, 9, 11, 22, 26, and 28. This type of failure increases the risk of patient harm or lapse in care as the ordering provider or subsequent providers may not be aware of this pertinent information being available to them. The quality of care was significantly impacted in the cases provided below:

- In case 4, medical records staff failed to retrieve and scan the results of the bone scan, the kidneys and bladder CT scan, and the abdominal and pelvic CT scan into the electronic medical record. The absence of this relevant information could have led to provider errors.

- In case 17, medical records staff stopped retrieving and scanning the patient's blood-thinning test results into the electronic medical record for a period of more than two months, resulting in nine deficiencies. As a result, relevant information needed by providers to guide the patient's anticoagulation treatment was absent from the electronic medical record.

- In case 26, medical records staff failed to retrieve and scan a hormone test result into the electronic medical record. As a result, relevant information needed by providers and offsite specialists to monitor and guide the treatment of the patient's hyperparathyroidism (excess parathyroid hormone) was absent from the electronic medical record.

Delayed scans of laboratory reports into the electronic medical record were found in cases 4, 19, and 28. These delays were moderate to significant with the majority due to medical records staff failing to timely retrieve and scan these reports into the electronic medical record. However, the quality of patient care was not significantly affected by these delays. Similar errors were found in the following cases:

- In cases 9, 19, 26, and 29, there were diagnostic reports that either lacked a provider signature or were not dated at the time of their review.
- In cases 19 and 28, there were the only instances of delays in providers' review of test results.
- In case 23, there were misfiled diagnostic reports.

Nursing

Nurse's notes were generally legible and were dated and signed. Deficiencies for completeness are also discussed in other indicators, including *Emergency Services*.

- In case 8, the transfer-in nursing documents were missing. The Confidential Medical/ Mental Health Information Transfer form (CDCR Form 7371) and Initial Health Screening form (CDCR Form 7277) provide valuable information about the patient's health care needs at the time of his arrival at CMF.
- In cases 5, 7, 9, 10, 12, and 15, MARs were misfiled or mislabeled making it difficult for providers to review patient compliance and blood glucose levels for diabetics taking insulin.

Urgent/Emergent Records

CMF nurses sometimes failed to properly document their urgent and emergent encounters. This is discussed in the *Emergency Services* indicator. CMF on-call providers did well with documenting their telephone encounters.

- Missing on-call provider documentation was identified in case 4.

Scanning Performance

The OIG clinicians identified mistakes in the document scanning process as mislabeled, misfiled, or incorrectly dated. Erroneously scanned documents can create delays or lapses in care by hindering providers' ability to find relevant clinical information. CMF performed adequately in this area. Scanning times for most documents were generally good. However, a few cases were identified in which CMF performed poorly in terms of scanning times for laboratory results and diagnostic and specialty reports into the electronic medical record. A few of these delays may have been due to providers' lateness in signing laboratory reports. These findings are further discussed in the *Diagnostic Services* and *Specialty Services* indicators.

- Case reviewers found mislabeled documents in the electronic medical record in cases 7, 8, 10, and 16.

- Misfiled documents (filed in the wrong chart) were found in case 25 and case 28.

- Mislabeled documents (scanned with the wrong date) were found in cases 5, 12, 17, 22, 28, and 30.

Legibility

Provider documentation was at times scant with certain providers failing to document their thought processes and reasoning in their progress notes. This often resulted in inadequate care management.

Illegible progress notes, signatures, or initials were in cases 6, 7, 13, and 29. Illegible progress notes pose a significant medical risk to patients, especially when the medical care must be reviewed by other staff or if a patient is transferred to a different care team. In addition to the extremely poor legibility that was also found during the Cycle 4 inspection, poor utilization of name stamps was also found in the Cycle 5 inspection. Signatures were either not dated or incorrectly dated in cases 23 and 29.

Clinician Onsite Inspection

The OIG clinicians observed clinical information transmission during the daily morning huddles. In addition, the OIG clinicians interviewed various health care staff regarding how information was handled, especially how clinical care occurred outside clinic and after hours. The OIG clinicians found that the process used by CMF to transmit information was adequate. While a standard huddle report agenda was used, important after-hours clinical information was distributed during morning huddles. Offsite specialty reports were also distributed to the providers by the nursing staff during morning huddles.

Despite what was observed at morning huddle, the OIG clinicians were informed by several providers during the onsite interviews that specialty reports were often directly scanned in the electronic medical record without their knowledge. Therefore, the providers only had access to these reports prior to scanning if they were made available during morning huddles, so providers would not be aware these reports were available for review as medical records had no process in place in which to notify them.

Furthermore, the medical records supervisor confirmed at the onsite interview that specialty reports were directly scanned into the electronic medical record regardless of whether or not a provider had reviewed the report. The medical records staff had not considered that this method of scanning had prevented providers from following CCHCS policy that required them to review specialty reports within three business days.

Clinician Summary

CMF continued to perform poorly with regard to documenting that important health care information had been reviewed by providers. Providers generally did not initial or date hospital discharge summaries or specialty consult notes after reviewing them. Also, providers failed to consistently document they had reviewed these reports in their progress notes. Furthermore, providers frequently failed to document their decision-making or thought process. At the onsite inspection, the OIG clinicians identified a significant failure in the transmission of information from specialty reports to providers. The OIG clinicians learned that higher priority was given to scanning specialty reports directly into the electronic medical record than to giving providers immediate access to these reports. Medical records staff further confirmed that specialty reports were often not made available to providers to review within three business days as per CCHCS policy. This failure by medical records to comply with CCHCS policy is a significant lapse as specialty reports frequently contain relevant medical information needed by providers to guide patient care. Therefore, this indicator was rated *inadequate*.

Compliance Testing Results

The intuition received an *inadequate* compliance score of 61.5 percent in the *Health Information Management* indicator, showing areas for improvement in the following areas:

- The institution scored zero in its labeling and filing of documents scanned into patients' electronic unit health records. Most errors consisted of mislabeled and misfiled documents. However, there was also a missing transcribed physician's progress note and one instance of a medication reconciliation order scanned into the incorrect patient's file. For this test, once the OIG identifies 24 mislabeled or misfiled documents, the maximum points are lost and the resulting score is zero. For the CMF medical inspection, inspectors identified a total of 24 documents with scanning errors (MIT 4.006).

- Among 25 sampled patients admitted to a community hospital and then returned to the institution, CMF's providers timely reviewed only 11 patients' corresponding hospital discharge reports within three calendar days of the patient's discharge (44 percent). For 14 of the sampled patients, providers did not timely review the discharge reports; nine reports were each reviewed one to two days late, three reports were reviewed from four to nine days late, one report was not received by the institution, and another report was not reviewed at all (MIT 4.007).

- Medical administrative staff did not always timely scan MARs into patients' electronic medical record files, scanning only 12 of 20 sampled documents (60 percent) within the required time frames. Staff scanned seven MARs between three and seven days late, and one was scanned 30 days late (MIT 4.005).

- Among 20 specialty service consultant reports sampled, CMF staff scanned 14 of the reports into the patient's health record file within five calendar days (70 percent). However, three documents were scanned between two and seven days late, one was scanned 32 days late, and two documents were not scanned at all (MIT 4.003).

CMF received *proficient* scores on two tests in this indicator:

- The OIG also tested 20 patients' discharge records to determine if staff timely scanned the records into the electronic medical record. All 20 samples were compliant (MIT 4.004).

- The institution timely scanned 19 of 20 sampled non dictated progress notes, patients' initial health screening forms, and requests for health care services into the electronic medical record (95 percent). One health care services request form was scanned one day late (MIT 4.001).

Recommendations

The OIG recommends CMF implement a local operating policy whereby specialty reports are required to be reviewed and signed by providers before they are scanned into the electronic medical record by medical records staff.

5 — *HEALTH CARE ENVIRONMENT*

This indicator addresses the general operational aspects of the institution's clinics, including certain elements of infection control and sanitation, medical supplies and equipment management, the availability of both auditory and visual privacy for patient visits, and the sufficiency of facility infrastructure to conduct comprehensive medical examinations. Rating of this component is based entirely on the compliance testing results from the visual observations inspectors make at the institution during their onsite visit.

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(82.4%)

Overall Rating:
Adequate

Compliance Testing Results

The institution received an *adequate* compliance score of 82.4 percent in the *Health Care Environment* indicator, with *proficient* scores in seven tests, as follows:

- All 14 clinics were appropriately disinfected, cleaned, and sanitary. More specifically, in all clinics, inspectors observed areas that were clean and not visibly dusty or dirty. In addition, cleaning logs were present and completed, indicating cleaning crews regularly cleaned the clinics (MIT 5.101).

- Inspectors examined CMF's 14 clinics to verify that adequate hygiene supplies were available and sinks were operable; all clinics were compliant (MIT 5.103).

- Health care staff at all 14 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105).

- All 14 clinics followed adequate protocols for managing and storing bulk medical supplies (MIT 5.107).

- Inspectors examined emergency response bags at three clinical areas to determine if the bags were inspected daily and inventoried monthly, and whether they contained all essential items. In all three inspected locations, the bags sampled were in compliance (MIT 5.111).

- Clinical health care staff at 13 of the 14 applicable clinics (93 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. One clinic had previously sterilized equipment that were missing date stamps (MIT 5.102).

- Clinic common areas at eight of the nine applicable clinics (89 percent) had environments conducive to providing medical services. One clinic could not provide auditory privacy during vital signs and triage assessments (MIT 5.109).

- OIG inspectors observed health care clinicians in each clinic to ensure they employed proper hand hygiene protocols. In 12 of the 14 clinics tested, clinicians adhered to universal hand hygiene precautions, scoring 86 percent. In two clinics, OIG inspectors observed clinicians who failed to wash or sanitize their hands before patient contact (MIT 5.104).

One test received an *adequate* score:

- Inspectors examined 12 clinics to determine if they had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination; 9 clinics (75 percent) were in compliance. Among the other three clinic locations, two had confidential records that were not shredded timely so they were accessible to inmate porters; one clinic had an exam table with torn vinyl; and one other clinic did not have a portable screen to ensure visual privacy (MIT 5.110).

The institution showed room for improvement in the following areas:

- The non-clinic bulk medical supply storage areas did not meet the supply management process requirements and did not support the needs of the medical health care program, scoring zero on this test. Medical supplies were found on the floor and subject to excessive heat or moisture. Medical supplies were also found stored beyond the manufacturer's guidelines (MIT 5.106).

- Only 9 of the 14 clinic locations (64 percent) met compliance requirements for essential core medical equipment and supplies. The remaining five clinics were missing medical supplies necessary to conduct a comprehensive exam. The missing items included a demarcation line for the Snellen eye exam chart, an AED, an emergency manual resuscitation bag (EMRB), and a nebulization unit (MIT 5.108).

Non-Scored Results

- The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported the ability to provide timely or adequate health care. The OIG does not score this question. When OIG inspectors interviewed health care managers, they did not identify any significant concerns. At the time of the OIG's medical inspection, CMF had several significant infrastructure projects underway, which included increasing clinic space, renovating the existing pharmacy, expanding medication distribution areas, and remodeling the TTA. These projects started in the fall of 2015, and the institution estimated that would be completed by the end of summer 2018 (MIT 5.999).

Recommendations

No specific recommendations.

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(62.7%)

Overall Rating:
Inadequate

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for *Inter- and Intra-System Transfers* include patients received from other CDCR facilities and patients transferring out of CMF to other CDCR facilities. The OIG review includes evaluation of the institution's ability to provide and document health screening assessments, initiation of relevant referrals based on patient needs, and the continuity of medication delivery to patients arriving from another institution. For those patients, the OIG clinicians also review the timely completion of pending health appointments, tests, and requests for specialty services. For patients who transfer out of the facility, the OIG evaluates the ability of the institution to document transfer information that includes pre-existing health conditions, pending appointments, tests and requests for specialty services, medication transfer packages, and medication administration prior to transfer. The OIG clinicians also evaluate the care provided to patients returning to the institution from an outside hospital and check to ensure appropriate implementation of the hospital assessment and treatment plans.

Case Review Results

The OIG clinicians reviewed 67 encounters relating to inter- and intra-system transfers, including information from both the sending and receiving institutions. These included 53 hospitalization events, each of which resulted in a transfer back to the institution. There were 36 deficiencies identified, 11 of which were significant, posing risk of serious patient harm (once each in cases 11 and 33; twice each in cases 15, 23, and 26; and three times in case 5).

Transfers

There was one significant nursing deficiency in this area.

- In case 33, the patient arrived at the institution from a hospitalization for a diabetic foot ulcer. The patient was admitted to the CTC. The nurse did not check the patient's blood glucose level and did not perform an adequate wound assessment. The nurse did not describe the wound's appearance, measure size and depth, indicate any type of drainage, or determine ulcer staging.

Hospitalizations

Patients returning from hospitalizations are some of the highest-risk encounters due to two factors. First, these patients are generally hospitalized for a severe illness or injury. Second, they are at risk due to potential lapses in care that can occur during any transfer. At CMF, the TTA RN performed a

focused assessment based on the reason for hospitalization. The TTA RN was also responsible for obtaining hospital discharge findings and recommendations and communicating them to the on-call provider. At CMF, TTA nurses noted "see attached" on the return progress notes, but did not describe the information received from the hospital.

- In case 4, the patient's diagnosis was new-onset congestive heart failure. The hospital recommended a follow-up cardiology consultation, but the consultation did not occur. In addition, a recommended one-week follow-up urology visit occurred beyond the requested time frame. This deficiency is counted in the *Specialty Services* indicator.

- In case 5, the patient returned from a hospitalization for pneumonia and sepsis (infection in the blood). The utilization management nurse's note indicated a plan to admit the patient to the CTC, but the provider on call was unaware of this and sent the patient to regular housing.

- In case 11, the patient returned from a hospitalization for acute kidney injury, poorly controlled diabetes, and hypertension. The TTA nurse did not perform any objective assessments except checking vital signs. The nurse did not look for any signs of edema (fluid retention), did not observe the skin for any break in integrity such as a bedsore, and did not assess pain level. The nurse's name was illegible on the notes. The pharmacy did not process provider orders to stop furosemide (diuretic) once a day and start furosemide twice a day. This deficiency is also included in the *Pharmacy and Medication Management* indicator.

- In case 13, medication orders were received but the nurse did not transcribe the orders until the next day. This resulted in a lapse in medication continuity.

- In case 15, the patient returned from a hospitalization with diagnoses of pulmonary edema (excess fluid in the lungs), hemoptysis (coughing up blood), acute bronchitis, and heart failure. The TTA nurse did not examine the patient's chest, did not observe the patient for edema, and did not document the dressing on the patient's foot. There was no evidence that the nurse reviewed the utilization management nurse's progress note or hospital discharge information. The TTA nurse did not notify the on-call provider of the hospital's recommendation to increase the furosemide dose. This medication change was never ordered. This case is also discussed in the *Pharmacy and Medication Management* indicator.

- In case 23, the patient was hospitalized for sepsis. The pharmacy did not process an order for antibiotics, so the patient never received them. Subsequently, the patient developed a recurrent infection requiring another hospitalization. This deficiency is also included in the *Pharmacy and Medication Management* indicator. This was an adverse event.

Minor deficiencies occurred when providers failed to sign hospital reports to indicate they were reviewed. This was seen in cases 4, 5, 13, 15, 22, 23 (on three hospitalizations), 25, and 26.

Clinician Onsite Inspection

Patients returning from hospital discharge were assessed by the TTA nurse. The case reviews indicated that TTA nurses did not perform adequate assessments and did not always discuss hospital discharge recommendations with the on-call provider. At the onsite visit, the TTA nurses interviewed and the nursing supervisor stated that the poor performance was likely due to their practice of not using CCHCS nursing protocol encounter forms. On-call providers rely on an adequate nurse's assessment to determine whether the patient's condition has improved sufficiently to return to the institution and if the patient is still appropriate for his prior housing unit. At CMF most hospital discharge recommendations were deferred for a decision by the primary care provider. Unfortunately, this resulted in missed medications and specialty follow-up consultations.

Conclusion

The OIG clinicians rated the *Inter- and Intra-System Transfers* indicator *inadequate.*

Compliance Testing Results

The institution scored in the *inadequate* range with a compliance score of 62.7 percent in this indicator, showing room for improvement in the following four areas:

- The OIG tested 25 patients who transferred into CMF from other CDCR institutions to determine whether they received a complete initial health screening assessment from nursing staff on their day of arrival. However, nursing staff neglected to answer all applicable questions for 19 of the 25 patients, resulting in a score of 24 percent (MIT 6.001).

- CMF scored 50 percent when the OIG tested four patients who transferred out of CMF during the onsite inspection to determine whether the patients' transfer packages included required medications and related documentation. Two patients had a keep-on-person (KOP) rescue medication prescription, but the medications were not included on the transfer packages at the time of transfer (MIT 6.101).

- Of 25 sampled patients who transferred into CMF, 23 had existing medication orders upon arrival; only 16 of the those 23 patients (70 percent) received their medications without interruption. Seven patients incurred medication interruptions of one or more dosing periods upon arrival (MIT 6.003).

- Among 20 sampled patients who transferred out of CMF to other CDCR institutions, 14 had their scheduled specialty service appointments properly included on the health care transfer form (70 percent) (MIT 6.004).

The institution performed in the *proficient* range in one area:

- Nursing staff timely completed the assessment and disposition sections of the screening form for all 25 patients sampled (MIT 6.002).

Recommendations

No specific recommendations.

7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(78.5%)

Overall Rating:
Adequate

This indicator is an evaluation of the institution's ability to provide appropriate pharmaceutical administration and security management, encompassing the process from the written prescription to the administration of the medication. By combining both a quantitative compliance test with case review analysis, this assessment identifies issues in various stages of the medication management process, including ordering and prescribing, transcribing and verifying, dispensing and delivering, administering, and documenting and reporting. Because effective medication management is affected by numerous entities across various departments, this assessment considers internal review and approval processes, pharmacy, nursing, health information systems, custody processes, and actions taken by the prescriber, staff, and patient.

Case Review Results

The OIG clinicians evaluated 60 events related to medications and found 43 deficiencies, 17 of which were significant.

Pharmacy Errors

- In case 4, the pharmacist wrote incorrect directions for insulin on the MAR and the medication reconciliation form. The directions were to administer insulin as needed for insomnia. Fortunately, medication nurses administered the medication correctly as ordered by the provider.

- In case 11, the pharmacy did not process provider orders to stop furosemide (diuretic) once a day and start it twice a day. This deficiency is also discussed in the *Inter- and Intra-System Transfers* indicator. This was a significant deficiency.

- In case 23, the pharmacy did not process an order for antibiotics, so the patient never received them. Subsequently, the patient developed a fever and required hospitalization. This was a significant deficiency, and is also discussed in the *Inter- and Intra-System Transfers* indicator.

Medication Continuity

Patients generally received their medications as prescribed and as scheduled. The OIG clinicians identified the following significant deficiencies related to hospitalizations and a transfer in:

- In case 8, Lovenox (blood thinner) was ordered and filled on the day the patient transferred into CMF, but the medication nurse did not administer the first dose until two days later.

- In case 13, the provider ordered an antibiotic to be administered the same day. The patient did not receive the antibiotic until the following day (two days after returning from a hospitalization).

- In case 15, the patient returned from the hospital with a diagnosis of pulmonary edema (excess fluid in the lungs). The hospital recommended a higher dose of furosemide, but the increase was never ordered by a provider.

- In case 23, the patient returned from the hospital with a diagnosis of sepsis (life-threatening blood infection). The provider ordered an antibiotic, but the nurse did not obtain the medication from the after-hours medication supply and did not administer the antibiotic at the next dosing time.

Medication Administration (Nursing)

These findings are discussed in the *Quality of Nursing Performance* indicator.

Clinician Onsite Inspection

The pharmacist in charge explained that CMF had four filters in place to ensure medication orders were filled and labeled accurately, pharmacy-generated documents were correct, and medications were available without lapses in continuity. Licensed vocational nurses (LVNs) and psychiatric technicians (PTs) responsible for medication administration were knowledgeable about medication preparation, medication administration safety, and operational processes on their assigned yards. The medication nurses stated they communicated with providers via faxes, emails, and telephone calls, but the medication nurses did not attend the morning huddle each day. The medication nurses reported they always called a custody officer in the patient's housing unit whenever a patient failed to report for a medication line, and they went to the patient's cell if necessary.

Clinician Summary

The institution provided appropriate pharmaceutical administration, and providers appropriately prescribed medications. In most cases reviewed, the pharmacy dispensed medications and made them available to medication nurses in a timely manner. Therefore, the OIG clinicians rated pharmacy and medication administration performance *adequate.*

Compliance Testing Results

The institution received an *adequate* compliance score of 78.5 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received an *inadequate* average score of 63.9 percent. The following three tests showed areas for improvement:

- Among 24 sampled patients, 9 (37 percent) timely received chronic care medications. For one patient, the nurse documented on the MAR that the patient was a "no show" but did not document any efforts to contact custody or to have the patient sent to the medication line. Three patients missed one or more doses of their DOT medications and did not receive provider counseling, and 11 patients did not receive their KOP medication for 30 or more days (MIT 7.001).

- CMF timely provided hospital discharge medications to only 12 of 25 patients sampled (48 percent). Discharge medications were delivered one to four days late for six patients; for two other patients, no evidence was found in the medical record that medications were provided. Four other patients did not receive their first dose of newly ordered medication, and one final patient received one of his medications two days late and did not receive the first dose of one other medication (MIT 7.003).

- Nursing staff administered medications without interruption to seven of ten patients who were en route from one institution to another and had a temporary layover at CMF (70 percent). For three patients, there was no medical record evidence that medications were administered as ordered (MIT 7.006).

The following test earned an *adequate* score:

- Of the 25 sampled patients at CMF who had transferred from one housing unit to another, 19 (76 percent) received their prescribed nurse-administered medications without interruption. Six patients did not receive one or more doses of their medications at the dosing time after the transfer (MIT 7.005).

The institution earned a *proficient* score on one test in this sub-indicator:

- Inspectors found that 22 of 25 patients sampled (88 percent) received their newly ordered medication in a timely manner. Two patients received their KOP medications one and 21 days late. For one final patient, there was no evidence of receipt or refusal of the ordered medication (MIT 7.002).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received an *adequate* score of 84.0 percent, including three *proficient* scores of 100 percent, as follows:

- The institution properly stored non-narcotic medications that did not require refrigeration at all applicable clinics and medication line storage locations inspected (MIT 7.102).

- At all six of the inspected medication line locations, nursing staff were compliant with proper hand hygiene protocols (MIT 7.104).

- Nursing staff at all six of the inspected medication line locations employed appropriate administrative controls and followed appropriate protocols during medication preparation (MIT 7.105).

Two tests received *adequate* scores:

- Nursing staff followed appropriate administrative controls and protocols when distributing medications to patients at five of six applicable medication preparation and administrative locations (83 percent). At one location, nursing staff did not ensure that the patient swallowed nurse-administered medications (MIT 7.106).

- Non-narcotic refrigerated medications were properly stored in 9 of 12 applicable clinic and medication line storage locations (75 percent). Three locations did not have designated area for return to pharmacy refrigerated medications; one location had several temperature readings that were outside the range specified by CCHCS policy (MIT 7.103).

The institution showed room for improvement in one area that scored *inadequate*:

- The institution employed adequate security controls over narcotic medications in only 5 of the 11 applicable clinic and medication line locations where narcotics were stored (46 percent). At six clinic and medication line areas, the narcotics log book lacked evidence on multiple dates that a controlled substance inventory was performed by two licensed nursing staff (MIT 7.101).

Pharmacy Protocols

In this sub-indicator, the institution received a *proficient* score of 86.7 percent, comprised of scores received at the institution's main pharmacy. Four out of the five tests in this sub-indicator received scores of 100 percent, as follows:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications that required refrigeration; and maintained adequate controls over and properly accounted for narcotic medications (MIT 7.107, 7.109, 7.110).

- CMF's pharmacist in charge timely processed all 25 inspector sampled medication error reports (MIT 7.111).

The institution scored poorly in one test in this sub-indicator:

- In its satellite pharmacies, CMF did not properly store non-refrigerated medications. Inspectors found intravenous fluids and oral medications stored beyond the manufacturer's guidelines (33 percent) (MIT 7.108).

Non-Scored Tests

- In addition to testing reported medication errors, OIG inspectors follow up on any significant medication errors found during the case reviews or compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information purposes only; however, at CMF, the OIG found no applicable medication errors (MIT 7.998).

- The OIG interviewed patients in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. All 10 of the sampled patients had access to their asthmatic inhalers and nitroglycerin medications (MIT 7.999).

Recommendations

No specific recommendations.

8 — *PRENATAL AND POST-DELIVERY SERVICES*

This indicator evaluates the institution's capacity to provide timely and appropriate prenatal, delivery, and postnatal services to pregnant patients. This includes the ordering and monitoring of indicated screening tests, follow-up visits, referrals to higher levels of care, e.g., high-risk obstetrics clinic, when necessary, and postnatal follow-up.

Because CMF is a male-only institution, this indicator did not apply.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

This indicator assesses whether various preventive medical services are offered or provided to patients. These include cancer screenings, tuberculosis screenings, and influenza and chronic care immunizations. This indicator also assesses whether certain institutions take preventive actions to relocate patients identified as being at higher risk for contracting coccidioidomycosis (valley fever).

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(68.3%)

Overall Rating:
Inadequate

The OIG rates this indicator entirely through the compliance testing component; the case review process does not include a separate qualitative analysis for this indicator.

Compliance Testing Results

The institution performed in the *inadequate* range in the *Preventive Services* indicator, with a compliance score of 68.3 percent. The following three tests showed areas for improvement:

- The institution scored poorly for monitoring of patients on tuberculosis (TB) medications. For five of the eight patients sampled, the institution either failed to complete monitoring at all required intervals, failed to document patients' weight, or failed to scan the monitoring form into the patient's medical record in a timely manner (27 percent) (MIT 9.002).

- OIG inspectors sampled 30 patients to determine whether they received a TB screening within the last year. Fifteen of the sampled patients were classified as a "Code 22" (requiring a TB skin test in addition to a signs and symptoms check), and 15 sampled patients were classified as "Code 34" (subject only to an annual signs and symptoms check). Nursing staff timely and appropriately conducted those screenings for only 15 of the 30 (50 percent). More specifically, nurses properly screened 9 of the Code 22 patients and 6 of the Code 34 patients. Inspectors identified the following deficiencies, and for some patients, more than one deficiency occurred (MIT 9.003):

    - For one of the Code 22 patients, an LVN or psychiatric technician read the test results rather than an RN, public health nurse, or primary care provider as required by the CCHCS policy in place at the time of the OIG's review.

    - For another Code 22 patient, nursing staff's documentation of the "signs and symptoms" review was incomplete.

    - For two Code 22 patients, the time of the TB test administration or reading was not documented to support that the test was completed within the required 48 to 72 hours.

- For four Code 22 patients, the TB test was read after 72 hours had passed.
- For nine Code 34 patients, nursing staff did not complete the required signs and symptoms review of the Tuberculin Testing/Evaluation Report (CDCR Form 7331).

- CMF scored poorly for the timely administration of TB medications. The OIG examined the health care records of all 11 patients who were on TB medications during the inspection period, and only 7 patients received all of their required medications (63 percent). More specifically, four of the 11 examined patients did not receive their medications on the provider-scheduled dates. Each of the four patients missed one or more scheduled dates, and none of them received provider counseling regarding his missed doses (MIT 9.001).

The following test scored in the *adequate* range:

- Inspectors tested whether patients who suffered from chronic care conditions were offered vaccinations for influenza, pneumococcal infection, and hepatitis. At CMF, 17 of 21 sampled patients (81 percent) received all recommended vaccinations at required intervals. For two patients, there was no evidence they received or refused a pneumococcal immunization within the last five years; one patient did not have a complete hepatitis A and B series, and the other patient was never started on the hepatitis A and B series (MIT 9.008).

The institution performed well in the following two areas:

- All 25 patients sampled timely received or were offered influenza vaccinations during the most recent influenza season (MIT 9.004).

- CMF offered colorectal cancer screenings to 22 of 25 sampled patients subject to the annual screening requirement (88 percent). For one patient, there was no medical record evidence either that health care staff offered a colorectal cancer screening within the previous 12 months or that the patient had a normal colonoscopy within the last ten years. One other patient sampled had an incomplete colonoscopy with no follow-up. For one final patient, although the screening was completed, it was 12 days late (MIT 9.005).

Recommendations

No specific recommendations.

10 — *QUALITY OF NURSING PERFORMANCE*

***Case Review Rating**:*
Inadequate
***Compliance Score**:*
Not Applicable

Overall Rating:
Inadequate

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process, and does not have a score under the OIG compliance testing component. Case reviews include face-to-face encounters and indirect activities performed by nursing staff on behalf of the patient. Review of nursing performance includes all nursing services performed on site, such outpatient, inpatient, urgent/emergent, inmate transfers, care coordination, and medication management. The key focus areas for evaluation of nursing care include appropriateness and timeliness of patient triage and assessment, identification and prioritization of health care needs, use of the nursing process to implement interventions, and accurate, thorough, and legible documentation. Although nursing services provided in the OHU, CTC, or other inpatient units are reported in the *Specialized Medical Housing* indicator and nursing services provided in the TTA or related to emergency medical responses are reported in the *Emergency Services* indicator, all areas of nursing services are summarized in this *Quality of Nursing Performance* indicator.

Case Review Results

The OIG clinicians reviewed 341 nursing encounters, 129 of which were outpatient nursing encounters. Most were for sick call requests, walk-in visits, and RN follow-up visits. In all, there were 172 deficiencies identified related to nursing care performance, 43 of which were significant.

Nursing Assessment

A major part of adequate nursing care is high-quality nursing assessments, including both subjective (patient interview) and objective (evaluation and observation) elements. The majority of nurses at CMF included both elements in their nursing assessments. However, most nurses did not utilize CCHCS nursing protocols and encounter forms, and their assessments were often incomplete and inadequate, as demonstrated in the following examples:

- In case 9, the patient complained of pain, burning, and tearing in his left eye. The patient had undergone cataract surgery less than two months prior. The sick call nurse did not test the patient's vision acuity, notify the primary provider, or refer the patient to the TTA for a same-day provider examination. The nurse did not recognize symptoms of a possible infection or other surgery complications.

- In case 14, the sick call nurse did not examine the patient's ear when he reported there was an insect in the ear canal. This could have caused an ear infection.

- In case 53, the sick call nurse did not perform an adequate assessment for a patient with headache, eye pain, nausea, and vomiting. Although the patient had migraine headaches, he had also suffered a head injury about five weeks earlier as well as had a prior stroke. Since the patient was prescribed warfarin, a blood thinner that can cause bleeding, his symptoms could have been due to internal bleeding.

- In case 60, the sick call nurse checked vital signs but did not address the diabetic patient's cold symptoms, earwax buildup, or toe pain. The patient submitted another sick call request, and the nurse again failed to assess the toe pain. Diabetes can cause poor circulation and numbness to the feet, which increases the patient's risk of developing sores or wounds.

Nursing Intervention

Since nurses at CMF did not consistently perform adequate assessments, nursing interventions were not always timely and appropriate. The nurses' failure to initiate nursing actions based on accurate and appropriate assessments increased the risk of harm.

- In case 10, the patient had multiple chronic medical conditions and recent confusion. He received intravenous fluids for very low blood pressure. CTC nurses failed to monitor the patient's blood pressure and his mental status for five hours during the night. The nurse on the next shift failed to insert a urinary catheter as ordered by the provider.

- In case 13, the provider ordered a wound culture. Two weeks later, the patient submitted a sick call request asking for a culture. The nurse noted that a face-to-face assessment was not done because there were no reported symptoms and referred the patient to the provider. The nurse did not contact the laboratory to check if the culture specimen had been collected. The provider addressed the patient's sick call request a week later.

- In cases 5, 10, 13, 15, 25, 28, and 33, nurses did not adequately describe the appearance of the patients' wounds and did not perform wound care as required. The lack of adequate descriptions hindered the ability to monitor whether healing was progressing and early identification of infection. The nurses' failure to perform wound care increased the risk of infection. In addition, the outpatient nurses did not intervene with the patients to attempt to resolve any "no-shows" to the clinic for dressing changes.

Nursing Documentation

Overall, nursing documentation in all areas of nursing services was adequate at CMF. However, the following deficiencies identified areas to target for further evaluation and implementation of quality improvement measures:

- In cases 4 and 6, the TTA nurse did not document the type of records received when the patient returned from hospitalization or an emergency room visit.

- In case 8, nurses repeatedly did not document the presence of an implanted intravenous catheter. The nurses did not observe the skin around the device for signs of irritation or infection.

- In case 26, there was no documentation of a nurse's assessment of the patient when he returned from a hospitalization.

Sick Call

The sick call process at CMF was timely but did not meet the majority of patients' needs regarding access to health care services. On multiple occasions, sick call nurses did not perform face-to-face assessments for patients who reported symptoms on the sick call request.

- In case 11, the sick call nurse did not perform a face-to-face assessment for a diabetic patient who reported infected toenails. The nurse noted the patient had seen the provider the previous day, but there was no evidence that the provider addressed this issue.

- In case 14, nurses did not perform face-to-face assessments for multiple sick call requests. The nurse did not assess the patient when he reported a possible knee injury sustained the previous day while he was being transported in a CDCR van. The patient submitted two requests, both of which were not addressed, for dilated pupils. The nurse also did not assess the patient when he complained of an intense rash.

- In case 26, the patient, who had a prior kidney transplant and lupus (inflammatory disease), submitted a sick call request for leg swelling. He also stated he had not received the compression hose ordered by the provider. The nurse did perform a face-to-face encounter, but left the upcoming provider visit to manage the patient in five days.

- In case 48, the sick call nurse did not assess the patient with two requests to be seen for a hand injury.

- In case 50, the diabetic patient had frequent urination, but the nurse did not perform a face-to-face evaluation.

- In case 51, the patient had symptoms of pain and dizziness, but the nurse did not perform a face-to-face evaluation.

Care Management

The role of the RN primary care manager includes assessing patients, initiating appropriate interventions to support goals in the patient's treatment plan, and monitoring patients with chronic health needs and those at increased risk for developing serious complications. At CMF, the nurse managers explained that each primary care clinic's RN served as the care manager for the patients assigned to that care team. The RN prepared for and actively participated in the daily huddles,

reviewed and made decisions about sick call requests, and performed patient sick call assessments. The RN followed each patient's chronic care management and provided patient education and teaching as needed.

Although CMF clinic staff had an interactive daily huddle process, there was no evidence that CMF had implemented the care management process for managing, coordinating, and monitoring patient care needs as described by the CCHCS Complete Care Model policy. For example, the OIG clinician case review findings demonstrated the lack of RN primary care managers as well as the inadequate system processes to support their ability to appropriately assess, coordinate, and advocate for needed health care services. RN care managers could ensure provider orders for laboratory tests and durable medical equipment were completed; intervene with patients failing to show for wound care, essential medications, and blood pressure checks; educate patients with diabetes and other diseases who are non-compliant with their treatment plans; and consult with other disciplines to improve patient compliance.

Urgent/Emergent

The TTA nurse responded to all medical emergencies at CMF. The health care first responders and TTA nurses provided appropriate care to patients during emergency medical responses. While several deficiencies were found, the general quality of emergency nursing care was good. This is further discussed in the *Emergency Services* indicator.

Hospital Returns

In the cases reviewed, patients returning to CMF after hospital discharge were assessed by a TTA nurse. The TTA nurses did not always provide adequate focused assessments of these patients based on the reason for their hospitalization or emergency room evaluation. Although the TTA provider generally ordered critical medications, the TTA nurses often did not review hospital discharge records upon the patient's return to CMF, instead deferring hospital discharge recommendations to the primary care provider for review during the next morning huddle. The *Inter- and Intra-System Transfers* and *Pharmacy and Medication Management* indicators also address these issues.

Specialized Medical Housing

Nursing in the CTC and OHU was inadequate. The OIG clinicians found that nurses did not appropriately monitor and assess patients and failed to initiate nursing interventions when indicated. This is further discussed in the *Specialized Medical Housing* indicator.

Transfers and Hospitalization

Nurses in the receiving and release center provided adequate nursing care services and documentation. Details further discussed in the *Inter- and Intra-System Transfers* and *Reception Center* indicators.

Offsite Return and Specialty Care

The telemedicine nurse generally reviewed current patient information prior to scheduled telemedicine appointments, documented the encounter, and appropriately assisted the provider. Telemedicine, specialty, and utilization management nurses tracked receipt of specialty provider reports for three days and then forwarded the issues to CCHCS. Delays were found in receiving specialty reports and in providers signing the reports This is further discussed in the *Specialty Services* indicator.

Medication Administration

The OIG clinicians found poor communication by the medication nurses to the providers, clinical pharmacist, and primary care nurses. In addition, medication nurses' attempts to locate patients who failed to come to the medication lines were insufficient, resulting in a number of missed essential medications. Primary care nurses and care management nurses did not follow up with non-compliant patients to educate and resolve their resistance to going to the medication line. These nurses also did not collaborate with the patients, other members of the primary care team, or other disciplines to assist patients who failed to make needed lifestyle changes to increase the efficacy of their medications.

- In cases 5 and 10, the medication nurse did not attempt to locate the patient when the patient did not go to the medication line for insulin.

- In case 6, medication nurses did not always document the patient's blood pressure, either on the medication administration record or on the vital sign log, before administering a blood pressure medication.

- In cases 10, 11, and 12, the medication nurse did not either notify the provider when the patients' blood glucose levels were severely out of control or notify the provider in a timely manner.

- In case 17, nurses documented on the medication administration record that furosemide (a diuretic) was administered once daily instead of twice daily as ordered on three days during an eight-day period. The provider was not notified until the patient became ill.

Warfarin Clinic

At CMF, warfarin was managed by the clinical pharmacist at the warfarin clinic. If an immediate dose change was needed, the pharmacist alerted the appropriate medication nurse by telephone. Abnormally high blood-thinning test results (a laboratory test that measures the time it takes for blood to clot) are sent to the TTA for initial review. The OIG clinicians found the following deficiencies:

- In case 9, the clinical pharmacist ordered starting a new dose of warfarin that day, but the medication nurse did not administer it until the next day.

- Also in case 9, on three other dates, the medication nurse documented on the medication administration records that warfarin was not given but did not include the reason and did not notify the provider or the warfarin clinic.

- Also in case 9, on another occasion, the medication nurse administered more than twice the ordered dose of warfarin. The next blood-thinning test result was very high.

- Finally, in another case 9 event, the patient's blood-thinning test result was low. The clinical pharmacist noted the patient had recently missed a dose of warfarin. However, the record did not show any missed doses. Due to this error, the clinical pharmacist did not adjust the warfarin dose. This occurred again a week later when the blood-thinning test result was even lower.

- In case 15, the patient was a no-show to the medication line for 8 days in a 16-day period and did not receive warfarin on those days. The medication nurse did not notify the provider until four doses were missed. The clinical pharmacist was not aware of the many missed doses at the next visit although the patient's blood-thinning test result was low. Additionally, on one occasion, a new dose of warfarin was also not started timely.

Clinician Onsite Inspection

Clinic nurses were generally well prepared for the clinic huddles, although there appeared to be a pattern of missing specialty and hospital reports for timely review. The OIG nurse clinicians interviewed nurses and other staff. Some nurses expressed concerns about inadequate staffing levels, a lack of communication with management, and poor morale. However, they stated they were hopeful about improvements due to changes recently implemented by the new CNE.

Clinician Summary

The OIG nurse clinician team facilitated a meeting with the CNE and nurse supervisory team to discuss specific cases reviewed and to ask questions resulting from the onsite visit. The CMF nurse managers had researched the cases presented and were well prepared to address the issues and describe interventions underway for any needed improvement. However, the OIG clinicians found patterns of significant deficiencies identified in Cycle 4 were still present in Cycle 5. These deficiencies have the potential to negatively impact patient well-being. The OIG rated the *Quality of Nursing Performance* indicator at CMF *inadequate*.

Recommendations

No specific recommendations.

11 — *QUALITY OF PROVIDER PERFORMANCE*

In this indicator, the OIG physicians provide a qualitative evaluation of the adequacy of provider care at the institution. Appropriate evaluation, diagnosis, and management plans are reviewed for programs including, but not limited to, chronic care programs, TTA, specialized medical housing, and specialty services. The assessment of provider care is performed entirely by OIG physicians. There is no compliance testing component associated with this quality indicator.

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 409 medical provider encounters and identified 125 deficiencies related to provider performance at CMF. Of the 125 deficiencies identified, 31 were significant. The OIG rated this indicator *inadequate*, finding the same strong pattern of deficiencies from one provider that occurred in Cycle 4 was continued in Cycle 5. While this pattern of provider performance was rated *adequate* in Cycle 4, the OIG found the lack of corrective action to be a significant failure on the part of the medical leadership.

Assessment and Decision-Making

While most of the CMF providers consistently made sound assessments and accurate diagnoses, the provider mentioned above was responsible for approximately 60 percent of the significant deficiencies identified in this indicator. An in-depth analysis of provider assessment and decision-making revealed that 23 out of the total 48 deficiencies were attributed to this provider. Therefore, poor assessment and misdiagnosis were common with this provider. Errors in provider assessment were identified in cases 5, 11, 15, 18, 19, 22, 23, 24, 25, 27, 28, 29, 30, and the following cases, including one case in which the patient died (case 4):

- In case 4, the patient was seen after being discharged from the CTC. He was newly diagnosed with congestive heart failure. Also, his kidney function had recently deteriorated. The patient had a very elevated blood pressure. The provider did not recheck the patient's blood pressure, instead discharging him to his housing unit without treating his blood pressure. In addition, the provider decreased the dose of the patient's blood pressure medication because of the kidney failure. However, this decrease would have likely further elevated the patient's blood pressure, putting him at risk for worsening heart failure. The provider should have either added a second blood pressure medication or changed the patient to an entirely different class of blood pressure medication that was not affected by kidney function. Either of these medication changes would have given the patient better blood pressure control. In addition, the provider did not transfer the patient to a higher level of care or to the TTA for closer monitoring. The provider failed to order a short interval nurse follow-up to monitor the patient's blood pressure.

- Also in case 4, in a separate instance, the patient had a critically elevated blood pressure of 198/90. The provider again did not consider transferring the patient to the TTA for further monitoring and treatment. The provider discharged the patient back to his housing unit without treating his blood pressure. The patient was found unresponsive 11 days later. He was pronounced dead in the TTA. This death may have been prevented if providers had appropriately addressed and treated the patient's uncontrolled blood pressure. This was an adverse event.

- In case 10, the patient was already on a high dose of morphine (90 mg per day). The provider further increased the dose to a dangerous level (135 mg per day). No indication was documented by the provider as to why the patient required this level of morphine, such as impaired functional status. The patient was hospitalized for severe side effects from the morphine the following month. This was an adverse event.

- In case 12, the patient's methadone (narcotic) dose was increased by the same provider referenced in case 10. The provider again failed to appropriately document why the patient's methadone was increased. No X-rays were available that provided objective information about the patient's lower back pain. While the provider documented the patient had an abnormal knee exam with "significant laxity" of the ligaments, this was a chronic issue that was unchanged from prior exams. Furthermore, no documentation indicated the patient had experienced any loss of function from his lower back or knee pain that would explain the need to increase the methadone.

- In case 13, the patient was discovered to have bedsores during an offsite neurosurgery follow-up for chronic back pain. On return to the institution, the provider did not thoroughly review the offsite specialty note. As a result, the provider failed to do an appropriate assessment, which included examining the patient. Due to this oversight, the provider remained unaware of the patient's condition until his bedsores began to bleed three weeks later.

- In case 17, the provider ordered gradually reduced antibiotic and steroid doses, but did not document a patient encounter on a progress note. The provider had never seen this patient before. Therefore, the provider should have examined the patient before ordering medications for him. Furthermore, the nurse documented the patient had an abnormally fast heart rate and a low blood pressure. However, it was not clear if the provider was even aware of these abnormal vital signs due to the absence of appropriate documentation.

Despite the preceding examples, good diagnostic skills were demonstrated by a majority of CMF providers, as illustrated in the following examples:

- In case 26, the providers expertly managed the patient's complex medical conditions, which included a transplanted kidney and systemic lupus erythematosus (condition in which the immune system attacks the body's tissues and organs). The providers coordinated his

multiple follow-ups with the offsite specialists and ensured that monthly laboratory tests used to monitor the patient's transplanted kidney were completed in a timely manner. In addition, the providers maintained good communication with the offsite specialists and often directly notified them about concerning laboratory results, such as when the provider contacted the transplant center directly because the patient's transplanted kidney function had worsened. Finally, the providers appropriately transferred the patient to the outside hospital when he developed pneumonia.

- In case 28, the patient was admitted to the CTC after he had a complicated surgery for tongue cancer. The provider expertly handled and coordinated the patient's care, which involved multiple follow-ups with several different specialists. The provider also scheduled timely laboratory tests requested by the different specialists involved in treating the patient's cancer. In addition, the majority of the patient's CTC follow-ups occurred within the time frame required by CCHCS policy. The provider further ensured the patient received his radiation and chemotherapy treatments within the time periods recommended by the cancer specialists. Despite the patient's repeated refusals to be examined, the provider continued to document relevant physical findings by closely observing the patient during follow-up visits.

Provider-Ordered Follow-up Intervals

The OIG clinicians found a pattern of providers not ordering appropriate follow-ups; most of these (cases 10, 12, and 19) were directly attributable to the particular provider discussed above. This pattern was found in cases 4, 10, 13, 19, 24, and the following:

- In case 12, the patient had uncontrolled diabetes as indicated by his significantly elevated HbA1c of 9.7 (laboratory test of average blood sugar levels). The provider waited until almost four months later to assess the patient while making no changes in the monitoring or treatment of his diabetes. Furthermore, the provider saw the patient at an earlier scheduled follow-up, but never addressed his uncontrolled diabetes during that visit. The patient's diabetic care was significantly delayed, which increased his risk of developing diabetic ketoacidosis, a life-threatening complication.

Review of Records

There was insufficient depth of review of medical records by providers in cases 5, 9, 11, and the following:

- In case 4, the patient was treated at an outside hospital after he developed new onset congestive heart failure. The provider failed to thoroughly review the patient's weight when he returned to CMF and did not realize the patient had gained 14 pounds after his hospital discharge. This weight gain was significant because it potentially indicated the patient's congestive heart failure had worsened.

- In case 22, the patient saw an offsite specialist and complained of having chest pressure for the past year. The provider did not thoroughly review the note from the offsite specialist and, therefore, was not aware of the patient's complaint. The patient's chest pressure was never addressed by the provider during the OIG's period of review.

- In cases 4, 5, 10, 12, 23, 24, and 30, the providers failed to do thorough reviews of the electronic medical record. As a result, the providers unnecessarily repeated laboratory tests the patient had already completed.

Emergency Care

CMF emergency care provider performance was excellent. In 2015, CCHCS headquarters changed the afterhours onsite physician coverage (medical officer of the day) to offsite coverage by telephone (physician on call). While this type of coverage can be challenging for a medically complex patient population, CMF providers adapted well to this change. Only one deficiency among of the 33 TTA encounters reviewed was attributable to providers. Furthermore, no provider deficiency was found that significantly affected medical care. In general, TTA and on-call providers made accurate assessments and triage decisions. Patients requiring higher levels of care were appropriately sent out.

Chronic Care

Chronic care performance was marginally adequate. CMF providers demonstrated fair skill and knowledge in caring for patients even though a few providers struggled with patients with complicated chronic medical issues. However, the majority of the deficiencies were attributable to the one provider previously discussed.

- In case 10, in multiple patient encounters, the provider failed to monitor or treat the patient's chronic care issues, including obstructive sleep apnea, hyperlipidemia, peripheral artery disease, paroxysmal atrial fibrillation (abnormal heart rhythm), benign prostatic hypertrophy, diastolic dysfunction (abnormal heart contractions), and the chronic use of amiodarone (cardiac medication). Furthermore, the provider failed to review the patient's blood glucose logs after having decreased his long-acting insulin. This would have revealed that the patient's diabetes was severely out of control and required closer monitoring by the provider.

- In case 12, the provider increased the patient's atorvastatin (cholesterol medication) despite documenting the patient's triglyceride level (blood fat) may not have been a fasting value. The provider should have ordered a repeat fasting triglyceride level to obtain an accurate test result before changing the patient's medication.

- In case 27, the telemedicine rheumatologist (arthritis physician) recommended slowly decreasing the patient's prednisone (steroid) dose for his sarcoidosis (inflammatory disease that affects multiple organs). While the provider ordered the decrease, the provider did not stop the patient's original dose of prednisone, resulting in the patient receiving nearly double

the dose of his prednisone. This placed the patient at an increased risk of negative side effects.

The following case demonstrated good provider care:

- In case 6, the provider appropriately managed the patient's recurrent chest pain. The provider referred the patient to an offsite cardiologist and then appropriately followed the cardiologist's recommendation and urgently referred the patient for a cardiac angiogram (imaging study of blood vessels of the heart). Also, the provider appropriately used conservative measures to treat the patient's chronic pain. The patient was given a steroid injection for his shoulder pain. Physical therapy was used to manage the patient's chronic back pain. Finally, the patient was closely monitored in the OHU by frequent provider follow-ups.

Anticoagulation at CMF was typically managed by the clinical pharmacist in the anticoagulation (warfarin) clinic. Both the clinical pharmacist and the providers monitored the patients' anticoagulation levels. Overall, the anticoagulation clinic performed adequately in warfarin monitoring and management. The clinical pharmacist generally ordered and reviewed laboratory tests in a timely manner. The clinical pharmacist also educated patients about how their blood-thinning test levels could potentially be affected by diet. Finally, the providers were involved in monitoring and adjusting a patient's warfarin dose if needed as demonstrated in the above case. There was one significant deficiency with anticoagulation management by CMF providers:

- In case 17, the clinical pharmacist failed to follow-up with the patient's very high blood-thinning test result. As a result, the patient's warfarin dose was not adjusted for a week until the provider appropriately decreased the dose.

Diabetic management at CMF remained inconsistent and continued to be provider dependent since the Cycle 4 inspection. Poor diabetic care was primarily demonstrated by the previously identified provider. This particular provider displayed inadequate assessment and poor decision-making, and ordered inappropriate follow-up intervals for patients.

- In case 19, the provider made several questionable decisions regarding the patient's diabetic treatment. For the majority of the case review, the provider failed to start the patient on insulin. The provider continued the patient on the same low-dose oral diabetic medication. As a result, the patient's HbA1c increased to 9.6 (goal is less than 7). The provider should have maximized the dose and added a second oral diabetic medication during the time the patient was not on insulin. The patient's diabetes remained uncontrolled for almost three months, and his HbA1c increased to 12.5, which increased his risk of developing acute and long term complications from diabetes. Also, the provider repeatedly ordered inappropriately long follow-up intervals for the patient. Despite the HbA1c of 12.5, the provider ordered an inappropriate follow-up interval of more than two months. The provider should have ordered

short interval follow-ups until the patient's diabetes was controlled and his critically elevated HbA1c was brought nearer to goal.

Specialty Services

CMF providers appropriately referred patients for specialty services. Details are discussed in the *Specialty Services* indicator.

Documentation Quality

Provider documentation quality was extremely poor. Many instances of insufficient documentation were identified during this case review. The most common were failure to address one or more medical problems and acute medical issues, inaccurate documentation to support a medical decision, or the lack of documentation altogether, particularly in afterhours TTA visits. Poor documentation was identified in cases 4, 6, 8, 9, 10, 13, 15, 16, 18, 19, 23, 25, 27, 28, 29, 30, and the following:

- In case 12, the patient was taken to the TTA for further evaluation after he fell. The provider failed to document a provider encounter, including a physical exam, to explain why an X-ray was ordered for the patient's knee. Furthermore, the provider did not document if the patient could safely ambulate back to housing.

- In case 14, although the provider documented that a CT scan of the neck and ultrasound of the carotids (neck artery) would be "arranged" for the patient as requested by the telemedicine specialist, the provider never actually ordered these scans. This demonstrates how inaccurate documentation can significantly impact or delay patient care.

- In case 26, the provider failed to thoroughly document the patient's symptoms and a physical exam in the progress note. This pattern of poor documentation was a common occurrence at CMF.

The majority of progress notes were handwritten by the providers at CMF, so legibility was an issue with most of them. The OIG clinicians also found evidence of "cloned" progress notes, which were notes on which outdated medical information was inappropriately carried forward to a current progress note. Providers used cloned notes instead of updating their progress notes in cases 4, 6, 7, and 17.

Health Information Management

CMF providers generally documented patient encounters on the same day. However, there was a significant problem with offsite specialty notes not being available to providers for timely review. This is discussed in detail in the *Health Information Management* indicator.

Clinician Onsite Inspection

The OIG clinicians observed the daily morning huddles that occurred at CMF. Please refer to the *Health Information Management* indicator for further details.

While many of the providers at CMF described their own morale as having improved since Cycle 4, the providers still reported that morale at CMF was generally "somewhat poor." CMF had many years of provider stability until the sudden loss of highly seasoned and experienced providers left the institution short-staffed, with four positions currently vacant. However, the medical leadership at CMF said that physician recruitment and retention would be greatly enhanced with the 15 percent salary increase pending for providers at this institution. The loss of these highly experienced providers had also placed a heavy burden on the remaining providers, who cared for a medically complex patient population. While CMF had experienced an influx of new providers, these providers needed time to adapt and learn a new medical delivery system, which was inherently different from systems typically used in non-correctional community health care settings. The inexperience of these new providers had, therefore, contributed to the deficiencies identified during the review process in Cycle 5. For example, the OIG clinicians had identified a second provider who was delivering substandard care in multiple case reviews for Cycle 5, but many of these deficiencies occurred when this provider was a new hire learning an entirely different medical delivery system. Furthermore, the OIG clinicians reviewed cases in which this same provider had demonstrated high-quality care, indicating that this provider's performance would likely continue to improve if given the appropriate mentoring and support.

The OIG acknowledges that medical leadership at CMF had been stable for many years due to the chief medical executive (CME) and chief physician and surgeon (CP&S). Also, both the CME and the CP&S were described as supportive and fair by most providers at CMF. The majority of providers also reported that medical leadership was accessible and willing to help the group. While the OIG commends the medical leadership for the long years of stability that CMF had enjoyed, the OIG is concerned that medical leadership at CMF had not objectively identified deficiencies in care. The lack of objectivity from medical leadership at CMF was best demonstrated by issues that were previously identified in Cycle 4 yet were ongoing in Cycle 5. During Cycle 4, the OIG reported that two providers were underperforming, demonstrating superficial chart review, inaccurate assessments, inappropriate decision-making, and poor patient follow-ups. During the onsite inspection for Cycle 4, the CME and CP&S not only were unaware of any quality concerns about their providers, but also denied that two of their providers could be performing at a substandard level.

One of these identified providers had, during Cycle 5, remained at CMF since Cycle 4, and the majority of significant deficiencies found during the Cycle 5 inspection were attributed to this provider. During the onsite interview, when asked by the OIG clinicians to explain some of the substandard care found, this provider was unable to respond to the questions posed and deferred to the CME.

During the medical leadership meeting, the CME and CP&S dismissed all of the concerns the OIG clinicians raised about the substandard care delivered by the identified provider. Both the CME and CP&S asserted there were no issues to address and that this provider delivered good patient care. The discordance between CMF and OIG provider evaluations was demonstrated further by the Performance Appraisal Summary that was completed by CMF six months after the last OIG onsite inspection in May 2016. At that onsite inspection, the OIG clinicians had expressed concerns about this provider's substandard care to the CMF medical leadership. However, the CP&S rated this same provider's quality of work as "excellent" on the Provider Appraisal Summary completed in December 2016. This disparity may have been due to CMF using an evaluation process that differed significantly from that used by the OIG in conducting case reviews. CMF used low-risk medical encounters in its provider evaluations. This was in marked contrast to the OIG's case review, which relies heavily on higher-risk and complex medical patients.

The OIG had recommended in Cycle 4 that CMF not perform its own peer reviews because the strong relationships that medical leaders had established with their long-standing providers would give the appearance that these reviews would not be objective. However, this pattern of peer review by CMF medical leadership continued in Cycle 5, as demonstrated in the Provider Appraisal Summary of the identified provider mentioned above. As long as CMF medical leadership was involved in evaluating any long-standing CMF provider, there would exist serious concern that substandard patient care would continue. Furthermore, the department could not hold these providers responsible for their inadequate performance if the CME and CP&S continued to rate substandard provider care "excellent." Ultimately, it was the medically complex patients at CMF who were potentially at risk of harm, and objective feedback was needed to improve provider performance, allowing better patient care to occur.

Finally, CMF voiced a concern that the review process used by the OIG may not have been an accurate reflection of provider performance, as CMF complained that the OIG was "cherry-picking" only complex medical cases to review. CMF requested that more of the "easier patients" with few or no medical issues be selected by the OIG to review. All stakeholders agreed on the methodology used by the OIG for medical inspections. The OIG cannot change the methodology simply at the request of an individual institution.

The practice of using less medically complex patients to accomplish the UHR Clinical Appraisals and Performance Appraisal Summaries does not accurately measure provider care at CMF. This is a medical institution that houses and provides care to some of the most medically complex patients in CDCR. If the institution used patients with few or simple medical issues to evaluate its providers, the OIG contends that this process would be flawed because it would represent only a small fraction of the medical population and, therefore, not reflect the vast majority of medically complex patients at CMF. The OIG contends that such a selective and limited patient pool to evaluate providers may further explain the significant discordance that exists between provider evaluations from CMF leadership and those from the OIG.

Conclusion

The care provided by the CMF medical providers was *inadequate*. Of the 25 cases reviewed, one was *proficient*, 18 were *adequate*, and 6 were *inadequate*. An in-depth analysis of the deficiencies identified from CMF providers during OIG case review revealed that approximately 60 percent of the deficiencies in Cycle 5 were attributed to the previously identified provider. Likewise, over 50 percent of the significant provider deficiencies were attributed to this provider. In Cycle 4, the OIG separated the poor care provided by the one physician to give an *adequate* rating to the *Quality of Provider Performance* indicator in hopes that CMF leadership would mitigate the harm done by this physician. In Cycle 5, the OIG could not separate the physician from the rating because leadership at CMF had failed to correct this provider's performance or to put into place other measures to ensure the medically complex patients were not placed at risk by this physician's care. The remaining CMF providers generally made adequate assessments and diagnoses. Also, the quality of care overall had decreased somewhat from Cycle 4, in part due to the recruitment of new providers and the loss of highly experienced physicians. The rest of the CMF providers appropriately referred patients for specialty services and provided excellent emergency care. Anticoagulation management was also good.

Recommendations

- The OIG recommends CCHCS further review the identified provider for at least six months. To ensure an objective peer review, the CME and CP&S should not be involved in this process.

- The OIG recommends that CCHCS reevaluate the process currently used to annually evaluate providers, and that CMF leadership review the medical care of complex patients to effectively evaluate providers' abilities.

12 — *RECEPTION CENTER ARRIVALS*

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

This indicator focuses on the management of medical needs and continuity of care for patients arriving from outside the CDCR system. The OIG review includes evaluation of the ability of the institution to provide and document initial health screenings, initial health assessments, continuity of medications, and completion of required screening tests; address and provide significant accommodations for disabilities and health care appliance needs; and identify health care conditions needing treatment and monitoring. The patients reviewed for reception center cases are those received from non-CDCR facilities, such as county jails.

Because CMF has no reception center, this indicator did not apply to this institution.

13 — *SPECIALIZED MEDICAL HOUSING*

This indicator addresses whether the institution follows appropriate policies and procedures when admitting patients to onsite inpatient facilities, including completion of timely nursing and provider assessments. The chart review assesses all aspects of medical care related to these housing units, including quality of provider and nursing care. CMF's specialized medical housing was comprised of a CTC, an OHU, and a hospice facility.

Case Review Rating:
Inadequate
Compliance Score:
Proficient
(91.2%)

Overall Rating:
Inadequate

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance testing resulting in a *proficient* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate.* The key decision factors were that the case review process includes a more robust assessment of the quality of health care provided, while the compliance review primarily assesses whether the medical housing units met required time lines in providing health care. As a result, the case review testing results were deemed a more accurate reflection of the appropriate overall rating.

Case Review Results

The OIG clinicians reviewed 376 events related to the *Specialized Medical Housing* indicator. There were 130 deficiencies, 15 of which were significant (once in cases 10, 29, and 33; twice in cases 4, 8, and 28; and three times in cases 5 and 17). CMF's performance as rated by the case review clinicians was *inadequate*.

Provider Performance

CTC and OHU providers continued to perform at high levels. Providers documented comprehensive history and physical exams as well as detailed discharge summaries that showed a thorough review of medical records had been performed. Providers also demonstrated excellent assessment and decision-making during patient care. However, there were three significant deficiencies:

- In case 5, the provider did not adequately review the hospital discharge packet that recommended holding atorvastatin (cholesterol medication) that was likely a factor in the patient's recent muscle pain and inflammation. However, the provider wrote to continue the medication before evidence of recovery was confirmed by laboratory testing.

- In case 17, a provider failed to record an encounter for a patient requiring antibiotics and steroids.

- In case 29, the provider failed to provide adequate assessment and management of a patient with an acute exacerbation of chronic obstructive pulmonary disease. The provider failed to

order a chest X-ray and a short-interval nursing follow-up given the patient's abnormal vital signs and past history of requiring mechanical respiratory life-support.

Nursing Performance

Nurses in the CTC documented brief daily patient assessments and the general status of the patients regarding their activities of daily living. However, documentation did not always reflect each patient's current condition. Nurses did not consistently monitor changes in patients' conditions and did not utilize the nursing process (assess patient, determine a nursing diagnosis, identify outcomes, plan nursing interventions, implement the interventions, and evaluate effectiveness of care). Nursing care plans and patient service plans are tools to communicate current patient problems and specific nursing care to promote individualized care and consistency among nursing staff. Nursing care plans were not comprehensive and were not revised when needed. This was especially apparent for patient falls. For these reasons, nursing performance in the CTC and OHU was rated as inadequate. Nursing performance in the Hospice was rated adequate. Examples of significant deficiencies are given below:

Falls

Patient falls in any specialized medical housing unit are serious events. CMF nurses and providers failed to take all necessary precautions to prevent falls and patient injury, as illustrated in the following examples:

- In case 5, the CTC nurse failed to reassess the patient's fall risk or revise the nursing care plan after a fall in physical therapy from which the patient suffered a fractured arm. On a subsequent date, the patient became dizzy during physical therapy and later that afternoon he fell in his room. The CTC nurse again did not reassess fall risk, implement nursing interventions such as fall precautions, or revise the nursing care plan.

- In case 7, the first watch hospice nurse did not notify the provider or the second watch nurse that the patient fell onto the floor and reported having blacked out.

- In case 8, the patient had a chronic hip fracture and cancer of the bone. CTC nurses failed to reassess his fall risk when he first complained of increased weakness due to chemotherapy. The patient subsequently had three falls, yet nurses still did not reassess his fall risk, initiate nursing interventions, or update the nursing care plan. Examples of possible nursing interventions for this patient would be to give the patient a urinal and bedpan or bedside commode, move him closer to the nurses' station for observation or ask the provider to order a sitter. The nurse did not assess the patient for injuries after one of the falls and again after the nurse noted a new bruise on the patient's thigh. When the patient complained of leg swelling, the nurse notified the provider but nurses on the following watches did not assess the leg for other signs and symptoms of a blood clot. The patient suffered another fall after he

was transferred to hospice, but nurses' documentation was not found in the electronic medical record.

- In case 10, the patient suffered a fall in the CTC and the nurse failed to reassess the patient's fall risk or revise the nursing care plan. The nurse did not assess the patient's condition prior to his discharge to general housing or inform the primary care team of the patient's transfer of care. The patient slid out of his lower bunk the next day.

OHU

- In case 6, the patient with significant heart disease was sent to the hospital for chest pain and shortness of breath. He signed out of the emergency room against medical advice. The OHU nurse did not actively check the patient during the night he returned as ordered by the provider. The nurse's instruction to the patient to use the call light if he had any symptoms was not sufficient. The nurse should have periodically checked vital signs, respiratory status and pain level. During the case review period, nurses did not monitor the frequency and effectiveness of the patient's self-administered breathing treatments.

- In case 13, nurses did not perform wound care as ordered and did not document adequate descriptions of the wound. Several nurses documented the patient's skin was intact while he had an ulcer in the area at the base of his spine.

- In case 17, the patient reported to the clinical pharmacist that he had the flu the previous week. The OHU nurses were not aware of the patient's recent illness, and did not assess the patient for medical symptoms during his stay in the OHU.

CTC

- In case 4, nurses on each watch did not consistently monitor fluid intake and urine output or urine characteristics for a patient on fluid restriction with a recent hospitalization for acute kidney injury and chronic kidney disease. Nurses did not recheck the patient's blood pressure when the blood pressures were significantly elevated to see if they were lower after a few minutes.

- Also in case 4, nurses did not adequately respond whenever the patient's blood glucose level was significantly high. Nurses did not assess the patient for signs and symptoms caused by high blood sugar and did not recheck the blood glucose level after giving the patient insulin to ensure the level had decreased.

- In case 5, when the patient returned to the CTC with a cast on his arm, nurses did not initiate a nursing care plan for the fractured arm and cast and did not document the presence of the cast for the first five days. Nurses did not assess circulation and sensation of the casted arm and hand on each watch.

- Also, in case 5, nurses did not perform wound care as ordered and did not document adequate descriptions of the patient's ankle wound. This allows staff to monitor the healing process and early detection of infection. During the case review period, nurses documented the patient's skin integrity as warm and dry without mention of the wound.

- In case 10, the patient received intravenous fluids for a very low blood pressure. The first watch nurse failed to adequately monitor the patient's blood pressure and mental status during the night. The second watch nurse did not notify the provider that the morning blood pressure was again low. On another date, the patient had an allergic reaction to a medication. The first watch nurse did not check the patient every two-three hours as ordered by the provider to ensure the signs and symptoms did not worsen during the night.

- In case 28, the patient performed his own wound care. Nurses did not observe the wound until it became infected. Nurses then did not evaluate the patient's wound care method to ensure he used the proper technique.

- In case 33, nurses did not perform wound care as ordered and did not document adequate descriptions of the wound.

Clinician Onsite Inspection

The OIG clinicians visited the units and interviewed nursing staff. In the CTC, there was a lead RN who transcribed provider orders, contacted the provider when needed, and communicated with other departments. A second RN made rounds, performed assessments of patients experiencing problems, and oriented patients admitted to the CTC. One of the CTC nurses interviewed was usually assigned to a different clinical area. The nurse was the shift lead but had not reviewed the care plans of patients experiencing difficulty. Hospice was a peaceful but active unit. The patients are fortunate to have a volunteer chaplain who is very involved with the patients and staff.

Conclusion

Nurses interviewed during the onsite inspection answered questions correctly about their unit's policies and procedures. However, case record reviews did not reflect that adequate and appropriate nursing care was provided to individual patients. The OIG clinicians found nursing performance in the hospice unit was adequate, but in the CTC and the OHU, it was inadequate. The OIG rated the *Specialized Medical Housing* indicator *inadequate*.

Compliance Testing Results

The institution scored in the *proficient* range in compliance testing in this indicator, with three of the four tests in receiving *proficient* scores, as follows:

- Providers evaluated all ten applicable sampled patients within 24 hours of admission and completed the required history and physical (MIT 13.002).

- When inspectors observed the working order of sampled call buttons in OHU, CTC, and Hospice patient rooms, inspectors found all working properly. In addition, according to staff members interviewed, custody officers and clinicians were able to expeditiously access patients' locked rooms when emergent events occurred (MIT 13.101).

- Nursing staff timely completed an initial health assessment for all ten CTC patients sampled. In the OHU, nursing staff completed six out of seven assessments within the required time frame; one patient's assessment was late (94 percent) (MIT 13.001).

One test received an *inadequate* score:

- The OIG tested whether providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required three-day intervals; providers completed timely SOAPE notes for 12 out of 17 sampled patients (71 percent). SOAPE notes for two patients were written one and four days late. For three other patients, there was no evidence in the electronic medical record that the SOAPE notes were written (MIT 13.003).

Recommendations

No specific recommendations.

14 — *SPECIALTY SERVICES*

This indicator focuses on specialist care from the time a request for services or physician's order for specialist care is completed to the time of receipt of related recommendations from specialists. This indicator also evaluates the providers' timely review of specialist records and documentation reflecting the patients' care plans, including course of care when specialist recommendations were not ordered, and whether the results of specialists' reports are communicated to the patients. For specialty services denied by the institution, the OIG determines whether the denials are timely and appropriate, and whether the patient is updated on the plan of care.

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(53.0%)

Overall Rating:
Inadequate

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both results and ultimately scored this indicator *inadequate*. The key factor that warranted the lower rating was that compliance testing revealed serious delays in the ability of patients to receive timely specialty care as ordered by their primary care providers.

Case Review Results

The OIG clinicians reviewed 345 events related to the *Specialty Services* indicator, the majority of which were specialty consultations and procedures. The OIG clinicians found 121 deficiencies in this category, 13 of which were significant, and rated this indicator *adequate*.

Access to Specialty Services

Case reviews found that specialty services were generally provided within adequate time frames for routine and urgent services. The majority of initial referrals to specialty services at CMF were completed within an acceptable time frame, except in case 14. However, delays in specialist follow-ups were found in cases 9, 11, 12, 13, 14, 23, 25, 27, 28, and the cases discussed below. Some of these delays had a significant effect on patient care, and there was one instance in which the specialist follow-up did not occur at all.

- In case 4, the patient was treated at an outside hospital after he developed new onset congestive heart failure. The hospital recommended the patient follow up with a cardiologist after his discharge. However, this follow-up never occurred during the review period. This deficiency is also discussed in the *Inter- and Intra-System Transfers* and *Quality of Provider Performance* indicators.

- In case 13, the patient had symptomatic, recurrent urinary tract infections due to his history of paraplegia (paralysis of the lower body) and a neurogenic bladder (flaccid bladder caused by

neurologic damage). The urologist ordered a four- to six-week week follow-up for the patient, but the follow-up was delayed for an additional two months.

- In case 23, the cardiologist requested a four-week follow-up for the patient, who had a history of irregular heart rate, a pacemaker, and aortic and mitral valve replacements. However, this follow-up never occurred during the review period.

Nursing Performance

Nursing care was adequate in telemedicine and returns from offsite specialty provider encounters. The OIG clinicians identified 18 nursing deficiencies, all minor, and most of which were related to offsite returns, assessments, documentation, and communication of recommendations.

The TTA nurses did not consistently perform adequate nursing assessments for patients returning from offsite specialty services. These superficial assessments generally consisted of vital signs alone, and did not include such areas as mobility, pain, a new cast, cardiac status, and respiratory status. These deficiencies occurred in cases 5, 6, 8, 9, 26, and 27.

TTA nurses did not consistently document the type of information received from the specialty provider, such as a completed Request for Services (RFS) (CDCR Form 7243), progress note, or consultation report. At a minimum, the specialist should provide a statement of findings and recommendations. If this information is not received, the TTA nurse should contact the specialty provider, request the information and document a verbal report in a progress note or on the RFS form. It is not sufficient for the TTA nurse to document on the offsite return progress note to see the attached information. This deficiency was found in cases 6, 9, 14, and 22. The OIG clinicians were not able to confirm if adequate information was obtained at the time of return due to the nurses' poor documentation.

The most serious type of deficiency was the failure of the TTA nurses to communicate the specialty provider's recommendations to a CMF provider.

- In case 4, the RN did not contact the provider to report a recommendation for a new medication. This resulted in a two-month delay in the patient receiving the medication.

- In case 14, the failure to communicate recommendations also resulted in delays for medications and tests.

Provider Performance

CMF providers performed proficiently when submitting referrals for specialty services. Furthermore, all referrals were submitted with the proper priority. However, the OIG clinicians found one case in which the quality of provider performance was substandard. This case involved offsite specialty services for a patient.

- In case 23, the provider did not realize the patient needed to have biopsies with the esophagogastroduodenoscopy (imaging procedure of the esophagus and stomach) to determine if he had esophageal dysplasia (pre-cancer changes). As a result, the provider failed to discuss with the gastroenterologist when to stop the patient's warfarin as he was at high risk of bleeding after a biopsy. Due to this oversight by the provider, the procedure was cancelled after the patient arrived at the outside hospital.

Health Information Management

The OIG clinicians found there were problems with the processing of specialty reports. Providers were not notified when specialty reports were retrieved. CMF continued the process that was observed in Cycle 4 of scanning nearly all specialty reports directly into the electronic medical record without a provider's initials or date to show when the reports were reviewed.

Clinician Onsite Inspection

The telemedicine clinic was clean. The nurse kept an organized tracking and scheduling system for all telemedicine appointments. No appointment backlog for telemedicine was reported. However, the OIG clinicians learned during the onsite interviews that higher priority was given to scanning specialty reports directly into the electronic medical record than to providers having access to these reports. These findings are discussed in detail in the *Health Information Management* indicator.

Clinician Summary

While providers did an adequate job identifying and initially referring patients when needed, significant issues continued in the processing of specialty reports. CMF continued to scan specialty reports directly into the electronic medical record irrespective of whether these reports had been reviewed by a provider. Despite this failure, CMF provided patients with the necessary specialty care. Therefore, the case review clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 53.0 percent in the *Specialty Services* indicator, with *inadequate* scores on every test, as follows:

- Providers timely received and reviewed 4 of the 14 applicable routine specialists' reports that inspectors sampled (29 percent). Of the ten remaining patients, for eight of them, providers reviewed the reports from 2 to 56 days late, and for the final two, there was no evidence that a provider reviewed the reports at all (MIT 14.004).

- When CMF denied a provider's request for specialty service, providers did not always communicate the denial to the patient within the required time frame so that the patient could consider alternative treatment strategies. Of the 16 denials sampled, only six patients (35 percent) received a timely notification, while 10 did not. Five patients' service denial

notifications were from 3 to 43 days late; for five other patients, there was no evidence of provider follow-up to discuss the denial (MIT 14.007).

- The institution timely denied providers' specialty service requests for 9 of 20 patients sampled (45 percent). Eleven specialty services requests were denied between one and six days late (MIT 14.006).

- When CMF providers ordered high-priority specialty services for patients, the ordering provider did not always review the specialty report within the required time frame. Providers reviewed 8 of the 15 sampled specialty reports timely (53 percent); one report was reviewed 28 days late; while six other reports were received 3 to 11 and 34 days late (MIT 14.002).

- When patients are approved or scheduled for specialty services at one institution and then transfer to another, policy requires that the receiving institution reschedule and provide the patient's appointment within the required time frame. Only 12 of the 20 applicable patients sampled who transferred to CMF with an approved specialty service (60 percent) received it within the required time frame. The remaining eight sampled patients did not timely receive their previously approved services. One patient had three approved services, of which CMF provided one service 48 days late and the other service were not provided at all; one other patient had two approved services, of which CMF provided one service 49 days late and the other service was not provided at all; two other patients had three approved services, of which CMF provided their services 12 and 43 to 48 days late and one of the patients did not have the service provided at all; one patient had three approved services and only one was provided timely, the other two services were 12 and 48 days late; and one patient received their services 7 and 99 days late. Finally, two other patients never received their services (MIT 14.005).

- For 11 of the 15 patients sampled (73 percent), high-priority specialty services appointments occurred within 14 days of the provider's order. Four patients received their specialty service appointments from one to 4 days late; and 10 and 25 days late (MIT 14.001).

- CMF provided routine specialty service appointments to 11 of 15 patients tested within the required time frame (73 percent). Four patients received their specialty service 3 and 4 days late; and 32 and 51 days late (MIT 14.003).

Recommendations

No specific recommendations.

15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(82.5%)

Overall Rating:
Adequate

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and patient deaths. The OIG verifies that the Emergency Medical Response Review Committee (EMRRC) performs required reviews and that staff perform required emergency response drills. Inspectors also assess whether the Quality Management Committee (QMC) meets regularly and adequately addresses program performance. For those institutions with licensed facilities, inspectors also verify that required committee meetings are held. In addition, OIG examines whether the institution adequately manages its health care staffing resources by evaluating whether job performance reviews are completed as required; specified staff possess current, valid credentials and professional licenses or certifications; nursing staff receive new employee orientation training and annual competency testing; and clinical and custody staff have current medical emergency response certifications.

The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied upon for the overall score for the institution.

Compliance Testing Results

The institution performed in the *adequate* range in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving a compliance score of 82.5 percent. The following 11 tests received *proficient* scores of 100 percent:

- The institution promptly processed all patient medical appeals in each of the most recent 12 months (MIT 15.001).
- The QMC met monthly, evaluated program performance, and took action when management identified areas for improvement opportunities (MIT 15.003).
- The OIG inspected incident package documentation for 12 emergency medical responses reviewed by the institution's EMRRC during the prior six-month period; all 12 sampled packages complied with policy (MIT 15.005).
- Inspectors reviewed the last 12 months of CMF's local governing body (LGB) meeting minutes and determined that the LGB met at least quarterly and exercised responsibility for the quality management of patient heath care each quarter, as documented in the meeting minutes. As a result, CMF scored 100 percent on this test (MIT 15.006).

- Based on a sample of ten second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).

- Medical staff promptly submitted the initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for all ten applicable deaths that occurred at CMF in the prior 12-month period (MIT 15.103).

- All ten nurses sampled were current with their clinical competency validations (MIT 15.105).

- All providers at the institution were current with their professional licenses. Similarly, all nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 15.107, 15.109).

- All pharmacy staff and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 15.110).

- All nursing staff hired within the most recent year timely received new employee orientation training (MIT 15.111).

The following test scored in the *adequate* range:

- Of the 12 providers at CMF, 10 had a proper clinical performance appraisal completed by their supervisor (83 percent). Two other providers received late probation reports, and one of the two had a late 360 Degree evaluation (MIT 15.106).

The following areas earned scores in the *inadequate* range:

- The institution had not taken adequate steps to ensure the accuracy of its Dashboard data. Although the institution provided substantial evidence of discussion of the methodologies used to conduct periodic data validation and the results of that data validation testing, the QMC meetings did not discuss methodologies used to train staff who collected Dashboard data and, therefore, CMF received a score of zero on this test (MIT 15.004).

- The OIG inspected records for five nurses over a two-month period to determine if their nursing supervisors properly completed monthly performance reviews. For four of the nurses, the supervisors' review did not include summarized aspects that were well done (20 percent) (MIT 15.104).

- The OIG tested provider, nursing, and custody staff records to determine if CMF ensured that those staff members had current emergency response certifications. CMF's providers were compliant, but nursing staff and custody managers were not. One RN had an expired BLS certification for nearly four months, and been working at the institution with the expired BLS certification. As a result, CMF received a score of 50 percent on this test (MIT 15.108). Also, the California Penal Code exempts custody managers who primarily perform managerial

duties from medical emergency response certification training; CCHCS policy, however, mandates that such managers have the certification. Since CCHCS does not have authority over custody staff, the OIG does not include custody records as part of the scoring of this test.

- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter. Only two of the three drill packages were properly completed (67 percent). For one drill, custody staff initiated basic life support, but there were no Crime/Incident Reports (CDCR Form 837-C) included in the drill package (MIT 15.101).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports. CCHCS' Death Review Committee (DRC) did not timely complete its death review summary for any of the ten CMF deaths that occurred during the OIG's inspection period. The DRC is generally required to complete a death review summary within either 30 or 60 days of death, depending on whether the death was expected or unexpected, and then notify the institution's CEO of the review results within 7 days so that any corrective action may be promptly pursued. For two patients deaths, the committee completed its summary 8 and 9 days late (38 and 39 days after death), and the institution's CEO was notified of the results 23 to 24 days late. For four patients' deaths, the committee completed its summary 21 to 39 days late (51 to 69 days after death), and the institution's CEO was notified of the results 27 to 52 days late. For three other patients deaths, the committee completed its summary 45 to 50 days late (75 to 80 days after death) and the institution's CEO was notified of the results 58 to 66 days late. Lastly, for the remaining patient death that occurred during the OIG's inspection period, the death review was 67 days late as of the OIG's inspection (MIT 15.998).

- The OIG discusses the institution's health care staffing resources in the *About the Institution* section on page *2* (MIT 15.999).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

The compliance testing and the case reviews give an accurate assessment of how the institution's health care systems are functioning with regard to the patients with the highest risk and utilization. This information is vital to assess the capacity of the institution to provide sustainable, adequate care. However, one significant limitation of the case review methodology is that it does not give a clear assessment of how the institution performs for the entire population. For better insight into this performance, the OIG has turned to population-based metrics. For comparative purposes, the OIG has selected several Healthcare Effectiveness Data and Information Set (HEDIS) measures for disease management to gauge the institution's effectiveness in outpatient health care, especially chronic disease management.

The Healthcare Effectiveness Data and Information Set is a set of standardized performance measures developed by the National Committee for Quality Assurance with input from over 300 organizations representing every sector of the nation's health care industry. It is used by over 90 percent of the nation's health plans as well as many leading employers and regulators. It was designed to ensure that the public (including employers, the Centers for Medicare and Medicaid Services, and researchers) has the information it needs to accurately compare the performance of health care plans. Healthcare Effectiveness Data and Information Set data is often used to produce health plan report cards, analyze quality improvement activities, and create performance benchmarks.

Methodology

For population-based metrics, the OIG used a subset of HEDIS measures applicable to the CDCR patient population. Selection of the measures was based on the availability, reliability, and feasibility of the data required for performing the measurement. The OIG collected data utilizing various information sources, including the electronic medical record, the Master Registry (maintained by CCHCS), as well as a random sample of patient records analyzed and abstracted by trained personnel. Data obtained from the CCHCS Master Registry and Diabetic Registry was not independently validated by the OIG and is presumed to be accurate. For some measures, the OIG used the entire population rather than statistically random samples. While the OIG is not a certified HEDIS compliance auditor, the OIG uses similar methods to ensure that measures are comparable to those published by other organizations.

Comparison of Population-Based Metrics

For the California Medical Facility, nine HEDIS measures were selected and are listed in the following *CMF Results Compared to State and National HEDIS Scores* table. Multiple health plans publish their HEDIS performance measures at the state and national levels. The OIG has provided selected results for several health plans in both categories for comparative purposes.

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

For chronic care management, the OIG chose measures related to the management of diabetes. Diabetes is the most complex common chronic disease requiring a high level of intervention on the part of the health care system in order to produce optimal results. CMF performed well with its management of diabetes compared to most state and national plans.

When compared statewide, CMF outperformed Medi-Cal in all five measures, and outperformed Kaiser Permanente in four of the five diabetic measures selected. Kaiser, both North and South regions, scored higher than CMF for diabetic blood pressure control.

Nationally, CMF outperformed Medicaid, Medicare, and commercial health plans in all five diabetic measures. CMF outscored the United States Department of Veterans Affairs (VA) in two of the applicable measures (minimization of poor diabetic control and diabetic eye exams) but scored lower than the VA for diabetic blood pressure control and diabetic monitoring.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to both older and younger adults, CMF outperformed all statewide and national plans. With regard to administering pneumococcal vaccines to older adults, CMF scored higher than Medicare but lower than the VA.

Cancer Screening

With respect to colorectal cancer screening, CMF was outperformed by all other health care entities, statewide and nationally. However, the institution's score was negatively affected by a 36 percent refusal rate.

Summary

CMF's population-based metrics performance reflected an adequate chronic care program in comparison to other reporting statewide and national health care plans. The institution may improve its scores for colorectal cancer screenings by reducing patient refusals through patient education.

CMF Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	CMF Cycle 5 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So.CA) 2016[3]	HEDIS Medicaid 2016[4]	HEDIS Com-mercial 2016[4]	HEDIS Medicare 2016[4]	VA Average 2015[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**97%**	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control (>9.0%)[6, 7]	**15%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**75%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90)[6]	**72%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**90%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**62%**	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)	**86%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**86%**	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	**62%**	-	79%	82%	-	63%	67%	82%

1. Unless otherwise stated, data was collected in March 2017 by reviewing medical records from a sample of CMF's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services *2015 HEDIS Aggregate Report for Medi-Cal Managed Care*.

3. Data was obtained from Kaiser Permanente November 2016 reports for the Northern and Southern California regions.

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2016 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.

5. The Department of Veterans Affairs (VA) data was obtained from the VA's website, www.va.gov.
For the Immunizations: Pneumococcal measure only, the data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.

6. For this indicator, the entire applicable CMF population was tested.

7. For this measure only, a lower score is better. For Kaiser, the OIG derived the Poor HbA1c Control indicator using the reported data for the <9.0% HbA1c control indicator.

APPENDIX A—COMPLIANCE TEST RESULTS

California Medical Facility Range of Summary Scores: 53.01%–91.18%	
Indicator	**Compliance Score (Yes %)**
1 – ***Access to Care***	80.63%
2 – ***Diagnostic Services***	64.94%
3 – ***Emergency Services***	Not Applicable
4 – ***Health Information Management (Medical Records)***	61.50%
5 – ***Health Care Environment***	82.43%
6 – ***Inter- and Intra-System Transfers***	62.71%
7 – ***Pharmacy and Medication Management***	78.54%
8 – ***Prenatal and Post-Delivery Services***	Not Applicable
9 – ***Preventive Services***	68.31%
10 – ***Quality of Nursing Performance***	Not Applicable
11 – ***Quality of Provider Performance***	Not Applicable
12 – ***Reception Center Arrivals***	Not Applicable
13 – ***Specialized Medical Housing (OHU, CTC, SNF, Hospice)***	91.18%
14 – ***Specialty Services***	53.01%
15 – ***Administrative Operations***	82.50%

Reference Number	1 – *Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	20	5	25	80.00%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	16	9	25	64.00%	0
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	30	0	30	100%	0
1.004	Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	25	5	30	83.33%	0
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	10	4	14	71.43%	16
1.006	Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	10	1	11	90.91%	19
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	21	4	25	84.00%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	13	12	25	52.00%	5
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100%	0
Overall percentage:					**80.63%**	

Reference Number	2 – *Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	0	10	10	0.00%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	9	1	10	90.00%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	8	2	10	80.00%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	10	0	10	100%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	9	1	10	90.00%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	0	9	9	0.00%	1
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	4	5	9	44.44%	1
Overall percentage:					**64.94%**	

3 – *Emergency Services*

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

Reference Number	4 – *Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	19	1	20	95.00%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	Not Applicable				
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	14	6	20	70.00%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	20	0	20	100%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	12	8	20	60.00%	0
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	0	24	24	0.00%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	11	14	25	44.00%	0
Overall percentage:					**61.50%**	

Reference Number	5 – *Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned and sanitary?	14	0	14	100%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	13	1	14	92.86%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	14	0	14	100%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	12	2	14	85.71%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	14	0	14	100%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.00%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	14	0	14	100%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	9	5	14	64.29%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	8	1	9	88.89%	5
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	9	3	12	75.00%	2
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	3	0	3	100%	11
Overall percentage:					**82.43%**	

Reference Number	6 – *Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	6	19	25	24.00%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	25	0	25	100%	0
6.003	For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	16	7	23	69.57%	2
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	14	6	20	70.00%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	2	2	4	50.00%	1
Overall percentage:					**62.71%**	

Reference Number	7 – *Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	9	15	24	37.50%	1
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	22	3	25	88.00%	0
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	12	13	25	48.00%	0
7.004	For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?	Not Applicable				
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	19	6	25	76.00%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	7	3	10	70.00%	0
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	5	6	11	45.45%	3
7.102	All clinical and medication line storage areas for non-narcotic medications: Does the Institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	13	0	13	100%	1
7.103	All clinical and medication line storage areas for non-narcotic medications: Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	9	3	12	75.00%	2
7.104	Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	6	0	6	100%	8
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	6	0	6	100%	8
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	5	1	6	83.33%	8
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	3	0	3	100%	0

Reference Number	7 – *Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	1	2	3	33.33%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	3	0	3	100%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	3	0	3	100%	0
7.111	Does the institution follow key medication error reporting protocols?	25	0	25	100%	0
Overall percentage:					**78.54%**	

8 – *Prenatal and Post-Delivery Services*

The institution has no female patients, so this indicator is not applicable.

Reference Number	9 – *Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	7	4	11	63.64%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	3	8	11	27.27%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	15	15	30	50.00%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	22	3	25	88.00%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	17	4	21	80.95%	4
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**68.31%**	

10 – *Quality of Nursing Performance*

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

11 – *Quality of Provider Performance*

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

12 – *Reception Center Arrivals*

The institution has no reception center, so this indicator is not applicable.

Reference Number	13 – *Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	16	1	17	94.12%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	10	0	10	100%	7
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	12	5	17	70.59%	0
13.101	For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	4	0	4	100%	0
Overall percentage:					**91.18%**	

Reference Number	14 – *Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	11	4	15	73.33%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	8	7	15	53.33%	0
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	11	4	15	73.33%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	4	10	14	28.57%	1
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	12	8	20	60.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	9	11	20	45.00%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	6	10	16	37.50%	4
Overall percentage:					**53.01%**	

Reference Number	15 – *Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	12	0	12	100%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	4	0	4	100%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	2	1	3	66.67%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	10	0	10	100%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	1	4	5	20.00%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100%	0
15.106	Are structured clinical performance appraisals completed timely?	10	2	12	83.33%	0
15.107	Do all providers maintain a current medical license?	13	0	13	100%	0
15.108	Are staff current with required medical emergency response certifications?	1	1	2	50.00%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100%	1

Reference Number	15 – *Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100%	0
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100%	0
Overall percentage:					**82.50%**	

APPENDIX B — CLINICAL DATA

Table B-1: CMF Sample Sets

Sample Set	Total
Anticoagulation	3
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	3
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	24
Specialty Services	4
	58

Table B-2: CMF Chronic Care Diagnoses

Diagnosis	Total
Anemia	4
Anticoagulation	4
Arthritis/Degenerative Joint Disease	7
Asthma	12
COPD	20
Cancer	3
Cardiovascular Disease	21
Chronic Kidney Disease	10
Chronic Pain	22
Cirrhosis/End Stage Liver Disease	2
Coccidioidomycosis	2
Deep Venous Thrombosis/Pulmonary Embolism	6
Diabetes	29
Gastroesophageal Reflux Disease	14
Gastrointestinal Bleed	1
HIV	1
Hepatitis C	17
Hyperlipidemia	27
Hypertension	42
Mental Health	10
Migraine Headaches	3
Seizure Disorder	7
Sleep Apnea	6
Thyroid Disease	5
	275

Table B-3: CMF Event – Program

Program	Total
Diagnostic Services	304
Emergency Care	49
Hospitalization	52
Intra-System Transfers In	11
Intra-System Transfers Out	3
Not Specified	5
Outpatient Care	453
Specialized Medical Housing	374
Specialty Services	338
	1,589

Table B-4: CMF Review Sample Summary

	Total
MD Reviews Detailed	25
MD Reviews Focused	0
RN Reviews Detailed	15
RN Reviews Focused	32
Total Reviews	72
Total Unique Cases	58
Overlapping Reviews (MD & RN)	14

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California Medical Facility			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic Care Patients (25)	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing Sick Call (5 per clinic) 30	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (25)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(0)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.008	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(24)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Returns From Community Hospital (25)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical Areas (14)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (5)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (25)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (10)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101-103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107-110	Pharmacy (3)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (10)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001-007	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (11)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Code 22, Annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, Annual Screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) *N/A at this institution*	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	CTC (17)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons CTC (all)	OIG inspector onsite review	• Review by location
Specialty Services			
MITs 14.001–002	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006-007	Denials (19)	InterQual	• Review date (3–9 months) • **Randomize**
	(1)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (5)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (10)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (12)	OIG Q:16.001	• All required performance evaluation documents
MIT 15.107	Provider licenses (13)	Current provider listing (at start of inspection)	• Review all

MIT 15.108	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff
			  ○ Providers (ACLS)
			  ○ Nursing (BLS/CPR)
			• Custody (CPR/BLS)

MIT 15.109	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months) •
MIT 15.998	Death Review Committee (10)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

July 24, 2017

Robert A. Barton, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for California Medical Facility (CMF) conducted from January 2017 to March 2017. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-9573.

Sincerely,

Janet Lewis

JANET LEWIS
Deputy Director
Policy and Risk Management Services
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Roy Wesley, Chief Deputy Inspector General, OIG
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